Section 1 of 2
LOUISIANA
FY 08-09

Community Mental Health Services Block Grant Application

FY 2009 Plan

September 1, 2008
Approved October 15, 2008

Office of Mental Health
Department of Health and Hospitals

LOUISIANA
FY 2009

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION

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LOUISIANA FY 2009
BLOCK GRANT PLAN

Part A

Context & Overview of FY 2009 Application

PART A: FACE SHEET

FISCAL YEARS COVERED BY THE PLAN (Please check as appropriate)

√ FY 2009

STATE NAME: **Louisiana**

DUNS#: **809927064**

I. AGENCY TO RECEIVE GRANT
AGENCY: **Office of Mental Health**
ORGANIZATIONAL UNIT: **Department of Health and Hospitals**
STREET ADDRESS: **628 N. 4th Street, 4th Floor, (P.O. Box 4049)**
CITY: **Baton Rouge** STATE: **LA** ZIP: **70821-4049**
TELEPHONE: **(225) 342-2540** FAX: **(225) 342-5066**

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: **Jennifer Kopke** TITLE: **Assistant Secretary**
AGENCY: **Office of Mental Health**
ORGANIZATIONAL UNIT: **Department of Health and Hospitals**
STREET ADDRESS: **628 N. 4th Street, 4th Floor, (P.O. Box 4049)**
CITY: **Baton Rouge** STATE: **LA** ZIP: **70821-4049**
TELEPHONE: **(225) 342-2540** FAX: **(225) 342-5066**

III. STATE FISCAL YEAR
FROM: **July 1, 2008** TO: **June 30, 2009**

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION
NAME: **Cathy Orman Castille, PhD, MP**
TITLE: **Block Grant Planner,**
Division of Planning, Data Management, & Compliance
AGENCY: **Office of Mental Health**
ORGANIZATIONAL UNIT: **Department of Health and Hospitals**
STREET ADDRESS: **628 N. 4th Street, 4th Floor, P.O. Box 4049**
CITY: **Baton Rouge** STATE: **LA** ZIP: **70821-4049**
TELEPHONE: **(225) 342-2540** FAX: **(225) 342-5066** EMAIL: cocastil@dhh.la.gov

EXECUTIVE SUMMARY
LOUISIANA FY 2009 - ADULT & CHILD/ YOUTH PLAN

The Louisiana Office of Mental Health (OMH) Block Grant Plan for FY 08-09 provides direction and implementation strategies for further development of the state's comprehensive, community-based mental health system. The core belief inherent in this Plan is that *treatment works:* people with mental illness recover and become productive citizens. The underlying values of the service system include the expectation that the system be *consumer and child centered*. The mental health program in Louisiana focuses on *education, prevention and recovery while teaching and enhancing resilience.* The locus of services, management, and decision making continues to rest at the *community level*. It is the aim of the service system to follow the direction provided by the *President's New Freedom Commission Report* and to offer individualized, evidence-based, culturally competent services in a seamless manner that assures adequate and equitable service access. Quality, efficiency, data-based decision making, and demonstrated positive client outcomes are basic expectations within the system.

In early 2008, Louisiana began a new administration at all levels (Governor, Department of Health and Hospitals, and the Office of Mental Health) and as a result, many changes are on the horizon for the State. With a strong background in healthcare at both the state and federal levels, Governor Bobby Jindal promises that improving the health of Louisiana citizens will be a priority in his administration. The new Assistant Secretary (i.e., Commissioner) of the Office of Mental Health, Jennifer Kopke, previously was the Executive Director of the Jefferson Parish Human Services Authority (JPHSA). JPHSA is the longest operating local governing healthcare entity in the state, and with her experience, qualifies Ms. Kopke to lead the state in transforming the mental health care system.

Due to Hurricanes Katrina and Rita, there is no argument that the recent past has been a trying time for the citizens of the state in many, many ways. Discussion of the direction of Louisiana after August, 2005 cannot be undertaken without reflection on the effects of the hurricanes. Throughout the Block Grant application, references are made to the effects of these devastating storms. Although much of the state has stabilized to post-hurricane functioning, interruption of consumer activities and clinical services has been unavoidable, and continues to be a problem in some areas, even three years hence. While the City of New Orleans and the Gulf Coast region sustained the most direct damage, the rest of the State also experienced repercussions from the storms. The sense of community is changed for all citizens, including Louisiana's children and elderly. For evacuees, their lives were uprooted, and even today, many have no homes, schools, or neighborhoods to return to. Those who have returned find their communities permanently changed. Other regions of the state have taken in evacuees; forever changing their schools, communities, and lives. For individuals with mental illness, the loss of community is perhaps the most profound loss of all. While the state can be said to be recovering from and coping with, the initial losses of clinic and hospital infrastructure, the out-migration of the healthcare workforce continues to be a major problem and severely interferes with the ability of OMH to serve consumers. The needs and priorities of the service system to respond to Hurricane Katrina and Hurricane Rita necessarily shifted both fiscal and human resources to respond to post-hurricane challenges. However, the storms, and now the new administration have also presented the *opportunity* for re-examination and transformation of the service system. It is with this optimism, hope, and enthusiasm that the FY 2009 Plan is presented.

As we prepare to submit this plan today, Friday, August 29th, 2008, there is yet another challenge ahead, with a potentially dangerous hurricane churning in the Gulf of Mexico. We are reminded that three years ago, the plan was submitted on Friday, and Hurricane Katrina made landfall three days later, on Monday, August 29th, 2005.

We are hopeful that history does not repeat itself, but we are confident that the Office of Mental Health is stronger and more prepared to respond to whatever challenges may come our way.

LOUISIANA FY 2009
BLOCK GRANT PLAN

Part B

Administrative Requirements, Fiscal Planning Assumptions, & Special Guidance

LOUISIANA FY 2009
BLOCK GRANT PLAN

Part B
Section I

Federal Funding Agreements, Certifications and Assurances

GOVERNOR'S AUTHORIZATION OF DESIGNATION LETTER THIS PAGE

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2008

I hereby certify that _____Louisiana _____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2006, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

~~Governor or~~ Governor Designee Date

Jennifer Kopke
Assistant Secretary
Office of Mental Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Assistant Secretary
APPLICANT ORGANIZATION LA Department of Health & Hospitals, Office of Mental Health	DATE SUBMITTED

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

Approval Expires: 08/31/2007

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.);
(g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	Title: Assistant Secretary
Applicant Organization Submitted: LA Department of Health & Hospitals, Office of Mental Health	Date Submitted:

PUBLIC COMMENTS ON THE CONTENT OF THIS PLAN ARE WELCOMED AND MAY BE SUBMITTED TO :

LOUISIANA OFFICE OF MENTAL HEALTH

Dr. Cathy Orman Castille, Block Grant State Planner
Office of Mental Health
Department of Health & Hospitals
628 N. 4th Street, 4th Floor
P.O. Box 4049
Baton Rouge, LA 70821-4049
225-342-2540
cocastil@dhh.la.gov

Dr. Brandon Romano, Child/ Youth Planner
Office of Mental Health
Department of Health & Hospitals
628 N. 4th Street, 4th Floor
P.O. Box 4049
Baton Rouge, LA 70821-4049
225-342-2540
bromano@dhh.la.gov

LOUISIANA MENTAL HEALTH PLANNING COUNCIL

Ms. Jennifer Jantz, Chair
Louisiana Mental Health Planning Council
POB 40517
5700 Florida Blvd, Suite 320
Baton Rouge, LA 70835-40517
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PLANNING COUNCIL LIAISON

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Public Comments on the Block Grant Plan are encouraged through a variety of means. The public is invited to submit comments to the Office of Mental Health after reviewing the document.

The Planning Council, consisting of 40 members representing all geographic areas of the State, is instrumental in developing priorities and directions for the Block Grant Plan each year. Input is solicited from consumers, family members, providers, and state employees who are all members of the Planning Council.

Each year, the Block Grant Plan is available for review via the Office of Mental Health website. Email notices are sent to the Regional Managers, LGE Executive Directors, and Planning Council members when the Block Grant Plan is initially placed on the website. The current draft of the Block Grant is placed on the OMH website publication link, with instructions for submitting comments.

In addition, during the Spring of 2008, a yahoo groups listserv was activated for the Planning Council. The listserv has provided a means for posting attachments and documents for the Planning Council, including drafts of the Block Grant application.

Plans are now submitted via the SAMHSA Web-based Block Grant Application System (BGAS), which provides another means of public access to the plan.

Bound hard copies of the plan are available at no charge to the public, and can be either picked up at the OMH State Office or mailed out by request. It is emphasized that public comment is encouraged, and feedback and suggestions for improvements are welcomed. The mechanism to enable this process is included, with contact information for the State Block Grant State Planner, the Planning Council liaison, and the Planning Council.

LOUISIANA FY 2009
BLOCK GRANT PLAN

Part B
Section II & III

CHILDREN'S SET-ASIDE
AND
MAINTENANCE OF EFFORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Set-Aside for Children's Mental Health Services

Data Reported by: State FY July 1, 2007 – June 30, 2008

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2007	Estimated/ Actual FY 2008
$1,202,120	$11,706,412	$16,043,045

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. Maintenance of Effort (MOE) Report

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion. States are required to submit State expenditures in the following format:

MOE Information Reported by: State FY July 1, 2007 – June 30, 2008

State Expenditures for Mental Health Services

Actual FY 2006	Actual FY 2007	Actual / Estimate FY 2008
$69,920,148	$64,724,082	$98,282,261

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

LOUISIANA FY 2009
BLOCK GRANT PLAN

Part B
Section IV

STATE MENTAL HEALTH PLANNING COUNCIL REQUIREMENTS

STATE MENTAL HEALTH PLANNING COUNCIL REQUIREMENTS - PLANNING COUNCIL CHARGE, ROLE, & ACTIVITIES
LOUISIANA FY 2009 - ADULT & CHILD/ YOUTH PLAN

Statewide planning and development towards a comprehensive, community-based system of care is guided through the efforts of the State Mental Health Planning Council originally established under PL 99-660 guidelines with full consumer/ family representation from all Local Governing Entities (LGEs) and Regions of the state. The Council fully embraces the vision statement in the *President's New Freedom Commission Report (2003)* "*We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.*"

The Council is responsible for review of the annual Block Grant Application/State Mental Health Plan together with Office of Mental Health (OMH) staff dedicated to this function. The current Planning Council includes 40 members who are primary consumers, family members, family members of children with emotional/ behavioral disorders, advocates, regional advisory council representatives, human service agency representatives, and state agency employees. The Council is geographically representative of the state, and includes members from diverse backgrounds and ethnicities. The Planning Council includes four standing committees (Membership, Finance, Advocacy, and Programs and Services) that oversee each of the functions entrusted to the Council. Through the work of the membership as a whole, as well as through the committees, the Council is an active participant in transformation by addressing the Goals highlighted by the *New Freedom Commission Report* reproduced in the Table below. For example, the Advocacy Committee is specifically involved in ensuring that Goals #1, #2, #3, and #4 are addressed. Likewise, the Programs and Services Committee addresses Goals #2, #5, and #6.

The President's New Freedom Commission on Mental Health Goals In a Transformed Mental Health System	
Goal 1	Americans Understand that Mental Health Is Essential to Overall Health.
Goal 2	Mental Health Care Is Consumer and Family Driven.
Goal 3	Disparities in Mental Health Services Are Eliminated.
Goal 4	Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.
Goal 5	Excellent Mental Health Care is Delivered and Research Is Accelerated.
Goal 6	Technology Is Used to Access Mental Health Care and Information.

In addition to reviewing the Block Grant Application/ State Mental Health Plan, the Planning Council also monitors, reviews, and evaluates the allocation and adequacy of mental health services within the state. The Planning Council serves as an advocate for adults with serious mental illness, children with serious emotional disturbance, and other individuals with mental illness or emotional problems. This includes continued efforts toward public education, education of its members, and endeavors to reduce the stigma of mental illness throughout the state. During FY 2008, the services of an official (Professional) Parliamentarian were included in the Planning Council contract. The Parliamentarian assisted in rewriting the bylaws of the Council and has aided in improving the efficiency and effectiveness of the Council by structuring the business meetings according to acceptable practice.

A policy was adopted by the Office of Mental Health in 2006 entitled OMH Federal Block Grant Allocation and Expenditure Policy. This policy established an inclusive system for the effective and efficient allocation, expenditure, monitoring, and accounting of Block Grant funds in order to promote accountability to the Center for Mental Health Services (CMHS), the Planning Council, and the OMH executive management. The policy establishes a *Joint Block Grant Budget Review Committee* that includes members of the OMH Planning Division, the OMH Fiscal Division, and the Budget Committee of the Planning Council; and is not to exceed six members. This oversight of the budget allocations and Intended Use Plans is an important part of the role of the Planning Council.

Another important function of the Planning Council is that of assisting in the development of Regional Advisory Councils (RACs). The RACs are similar in purpose to the Planning Council, but with interests specifically geared toward activities in their respective areas, and are to be the lead agencies in advising how Block Grant funds will be allocated locally. Effective July 1, 2007, each Regional Manager (or LGE Executive Director) was directed by the OMH Assistant Secretary to allocate a minimum of $5,000 yearly of Block Grant funding to their respective RAC to support the functioning of the Regional Advisory Councils. Regional managers have been instructed to work with the RACs to develop an annual budget. RAC membership is reflective of that of the Planning Council, in that it consists of members who are primary consumers, family members, family members of children with emotional/ behavioral disorders, advocates, regional advisory council representatives, human service agency representatives, and state agency employees. The Planning Council Liaison has begun conducting onsite evaluations of the ten regions and local governing entities across the state to assure that they are viable, functioning organizations. The liaison has worked enthusiastically with individual executive committees, RAC chairs, and Regional Managers/ Executive Directors to assist in RAC development and functioning; as well as encouraging compliance to state and federal policy and regulations. Some issues that have been addressed have included revision of outdated by-laws, recruitment efforts for consumer-based membership, and full transparency in local budgets and block grant expenditures.

Louisiana is currently in the process of a mental health care system change from interrelated Areas and Regions to a system of independent health care districts or authorities, known as Local Governing Entities (LGEs) under the general administration of the Office of Mental Health. In the past, Community Mental Health Centers (CMHCs) and State hospital programs were all operated by State civil servants with direct line of authority from the Office of Mental Health central office. Local Governing Entities are mandated as the local umbrella agencies to administer State-funded mental health, addictive disorder and developmental disability services in an integrated system within their localities. It is anticipated the LGEs will enable greater accountability and responsiveness to local communities, since it is based on local control and local authority. At this time, Louisiana has 4 Local Governing Entities and 6 Regions.

On March 31, 2008, Ms. Jennifer Kopke assumed the position of Assistant Secretary for the Office of Mental Health and will be responsible for the planning and delivery of mental health services, as well as the statewide development of the human services district model of care. Ms. Kopke previously served as Executive Director of Jefferson Parish Human Services Authority and will guide the Office of Mental Health and the state of Louisiana as it moves toward a human services delivery model. The Planning Council's membership is listed below, along with the duties, responsibilities, role and charge as described in the newly revised Planning Council By-Laws below:

Louisiana Mental Health Planning Council
Membership List – 2007 - 2008

Revised – 08.04.08

KEY (By Federal Regulation, ALL MEMBERS must be categorized according to these groupings):					
State Employee	**Consumers/ Survivors/ Ex-patients**	**Family Members of Children with SED**	**Family Members of Adults with SMI**	**Others (Not state employees or providers)**	**Providers**

Agency/ Org. Represented	#	Name	Type of Membership	Address, Phone & Fax/ Email
STATE AGENCY MEMBERS MANDATED BY FEDERAL REGULATION.				
Office of Mental Health	1	Darling, Ann	State Employee	Office of Mental Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-2563 (work) 225-342-1984 (Fax) adarling@dhh.la.gov
Education	2	Groover, Melissa	State Employee	La Department of Education 1201 N. 3rd Street, 4th Floor P.O. Box 9064 Baton Rouge, LA 70804-9064 225-342-3351 225-219-4454 (Fax) Melissa.Groover@la.gov
Vocational Rehabilitation	3	Martin, Mark	State Employee	La Rehabilitation Services 3651 Cedarcrest Baton Rouge, LA 70816 225-295-8900 225-295-8966 (Fax) mmartin@dss.state.la.us
Housing	4	Brooks, Barry E.	State Employee	LA Housing Finance Agency 2415 Quail Drive Baton Rouge, LA 70808 225-763-8773 225-763-8749 (Fax) bbrooks@LHFA.state.la.us mbrooks@LHFA.state.la.us

Department of Social Services	**5**	**Williams, Lydia**	**State Employee**	**Office of Community Services** **627 N. 4th Street** **POB 3318** **Baton Rouge, LA 70821** **225-275-0372** **225-342-0963 (Fax)** **lwillil1@dss.state.la.us**
Criminal Justice	**6**	**Larisey, Sue**	**State Employee**	**Dep't of Public Safety & Corrections** **660 N. Foster Drive** **Baton Rouge, LA 70806** **225-922-1300** **225-291-9349 (Fax)** **slarisey@oyd.louisiana.gov**
STATE AGENCY MEMBERS INVOLVED IN DEVELOPMENT OF BLOCK GRANT PLAN				
State Planner	**7**	**Castille, Dr. Cathy**	**State Employee**	**Office of Mental Health** **628 N. 4th Street** **P.O. Box 4049** **Baton Rouge, LA 70821-4049** **225-342-9528** **225-324-1984 (Fax)** **cocastil@dhh.la.gov**
Child State Planner	**8**	**Romano, Dr.Brandon**	**State Employee**	**Office of Mental Health** **628 N. 4th Street** **P.O. Box 4049** **Baton Rouge, LA 70821-4049** **225-342-0590** **225-324-1984 (Fax)** **bromano@dhh.la.gov**
STATE AGENCY MEMBERS MANDATED IN STANDING RULES				
Medicaid	**9**	**Brown, Pamela G.**	**State Employee**	**Bureau of Health Services Financing** **POB 91030** **628 N. 4th Street** **Baton Rouge, LA 70821-9030** **225-342-6255** **225-376-4662 (Fax)** **pgbrown@dhh.la.gov**
Alcohol & Drug Abuse	**10**	**Bankston, Guadalupe**	**State Employee**	**Office for Addictive Disorders** **628 N. 4th Street** **P.O. Box 3868** **Baton Rouge, LA 70821** **225-342-9354** **225-324-3931 (Fax)** **gbanksto@dhh.la.gov**

Developmental Disabilities	**11**	**Katz Dr. Harold**	**State Employee**	**Office for Citizens with Developmental Disabilities 628 N. 4th Street POB 3117 Baton Rouge, LA 70821-3117 225-342-0095 225-342-8823 (Fax) hkatz@dhh.la.gov**
Office of Public Health	**12**	**Wightkin, Dr. Joan**	**State Employee**	**Office of Public Health 1450 L & A Road Metairie, LA 70001 504-219-4630 504-583-4404 (cell) jwightki@dhh.la.gov**
ADVOCACY ORGANIZATIONS MANDATED IN STANDING RULES				
Meaningful Minds of Louisiana	**13**	**Glover, Carole**	**Other (not state employee or provider)**	**1345 S. Willow St. #13 Lafayette, LA 70506 337-234-6291 Cglover211@bellsouth.net**
Louisiana Federation of Families for Children's Mental Health	**14**	**Boyd, Verlyn "Vee"**	**Other (not state employee or provider)**	**5627 Superior Dr. Ste A-2 Baton Rouge, LA 70816 225-293-3508 225-293-3510 (Fax) volboyd@laffcmh.org**
National Alliance on Mental Illness - Louisiana	**15**	**Jantz, Jennifer Council Chair**	**Other (not state employee or provider)**	**5700 Florida Blvd., Suite 320 P.O. Box 40517 Baton Rouge, LA 70835-40517 225-926-8770 225-926-8773 (Fax) namilajj@bellsouth.net namilouisiana@bellsouth.net**
Mental Health America of Louisiana	**16**	**Thomas, Mark**	**Other (not state employee or provider)**	**660 N. Foster Drive, Suite C - 201 Baton Rouge, LA 70806 225-201-1930 225-201-1949 (Fax) mthomas@mhal.org**
American Association of Retired Persons in Louisiana	**17**	**Blacher Daryl**	**Other (not state employee or provider)**	**301 Main Street Baton Rouge, LA 70801 225-376-1144 225-387-3400 (Fax) dblacher@aarp.org**
The Extra Mile	**18**	**Corkran, Candace**	**Consumer/ Survivor/ Ex-patient**	**1900 Lamy Lane, Suite 1 Monroe, LA 71201 318-388-6088 318-388-6872 (Fax) 318-801-0759 (Cell) theextramile@bellsouth.net**

REGIONAL ADVISORY COUNCIL REPRESENTATIVES	These individuals are either RAC Chairs or other representatives from the RAC <u>One person per Region/ LGE</u>			
MHSD	**19**	**Miller, Rev. Donald**	**State Employee**	**5120 Easterly Circle New Orleans, LA 70128 985-626-6318 985-626-6640 (Fax) dpmiller@dhh.la.gov**
CAHSD	**20**	**Jack, Nina**	**Other (not state employee or provider)**	**2124 Wooddale Blvd. Baton Rouge, LA 70806 225-925-2372 (work) 225-317-1246 (cell) njack@voagbr-clvs.org**
Region 3	**21**	**Martin, Brenda P.**	**Consumer/ Survivor/ Ex-patient**	**217 North French Quarter Houma, LA 70364 985-580-3352 985-876-8897 bpmartin@dhh.la.gov**
Region 4	**22**	**Nobles, Denver**	**Consumer/ Survivor/ Ex-patient**	**P.O. Box 1264 Scott, LA 70583 337-849-6764 lafayetteredneck@yahoo.com**
Region 5	**23**	**Griffin, Carolyn B.**	**Family Member of Adult with SMI**	**2700 General Moore Ave. Lake Charles, LA 70615 337-477-8897 cargri@bellsouth.net**
Region 6	**24**	**Dennis, Jr. Victor B.**	**Other (not state employee or provider)**	**257 Stilley Road Pineville, LA 71360-5934 318-473-2273 318-623-4547 (cell) vdennisj@bellsouth.net**
Region 7	**25**	**Bradley, Debra**	**Consumer/ Survivor/ Ex-patient**	**934 Unadilla Street Shreveport, LA 71106 318-868-6964 318-564-2853 bradleydebra41@yahoo.com**
Region 8	**26**	**Perry, Kathy**	**Consumer/ Survivor/ Ex-patient**	**2005 Roggerson Road, Apt. B Monroe, LA 71201 318-855-6059 318-914-3162 Kdp432001@yahoo.com**
FPHSA	**27**	**Ensley, Jim**	**Family Member of Adult with SMI**	**POB 1964 Covington, LA 70434 888-521-2297 (leave message) jimensley@charter.net**
JPHSA	**28**	**Noble, Rubye**	**Family Member of Adult with SMI**	**POB 8857 Metairie, LA 70011 504-835-5427 504-835-5424 (fax) rubyenoble@ren.nocoxmail.com**

INDIVIDUAL REPRESENTATIVES	These individuals <u>can</u> be on the RAC, but do not have to be. <u>One person per Region/ LGE</u>			
MHSD	**29**	**Marrero, Shirley**	**Family Member of Child with SED**	**8967 GSRI Ave Baton Rouge, LA 70810 (evacuee) 225-766-0228 225-284-5631 (cell) shirleymarrero@yahoo.com**
CAHSD	**30**	**Mong, Stanley**	**State Employee**	**4615 Government Street Baton Rouge, LA 70806 225-925-1768 225-922-2175 (fax) smong@dhh.la.gov**
Region 3	**31**	**Jones, Maletta**	**Family Member of Child with SED**	**6907 Alma Street Houma, LA 985-876-8874 mljones@dhh.la.gov**
Region 4	**32**	**Mullen, Joy**	**Consumer/ Survivor/ Ex-Patient**	**111 Paige Street Duson, LA 70529 337-988-4043 Joy4recovery@cox.net**
Region 5	**33**	**McMahon, LaShanda**	**Family Member of Child with SED**	**POB 103 Fenton, LA 70640 337-756-9210 lashandam@centurytel.net**
Region 6	**34**	**Cobb, Cynthia**	**Family Member of Child with SED**	**POB 5334 Alexandria, LA 71307 318-484-6264 (w) 318-443-1554 (h) Ccobblaff6@yahoo.com**
Region 7	**35**	**Davis, Gloria**	**Family Member of Child with SED**	**6299 Carrol Circle Shreveport, LA 71107 318-868-6964 Davi6814@bellsouth.net**
Region 8	**36**	**McKnight, Kaye**	**Family Member of Child with SED / (and) Consumer/ Survivor/ Ex-patient**	**912 St. John Street Monroe, LA 71201 318-322-5975 318-801-1571 (cell) 318-388-6088 kayeextramile@yahoo.com**
FPHSA	**37**	**Gutowski, Cindy**	**State Employee**	**FPHSA/ Mental Health Services 202 East Robert Street Hammond, La. 70401 985-543-4046 985-543-4204 (fax) cygutows@dhh.la.gov**

JPHSA	**38**	**Gibson, Elaine**	**Family Member of Child with SED**	**2725 Doreen Lane Marrero, LA 70072 504-342-3028 504-427-8962 (cell) Gibsonelaine@bellsouth.net**
INDIVIDUAL MEMBERS AT-LARGE				
At-large (CAHSD)	**39**	**Kauffman, Steve**	**Consumer/ Survivor/ Ex-Patient**	**Advocacy Center 8225 Florida Blvd., Ste. A Baton Rouge, LA 70806 225- 925-8884 225-281-6131 (cell) skauffman@advocacyla.org**
At-large (Region 5)	**40**	**Raichel, Clarice**	**Family Member of Adult with SMI**	**POB 1824 Lake Charles, LA 70602 337-433-0219 337-433-1860 (fax) namiswla@bellsouth.net**

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Louisiana Mental Health Planning Council
Composition by Type of Member – 2007 - 2008
Revised 08/04/2008

Type of Membership	Number & Percentage of Total Membership
TOTAL MEMBERSHIP	**40 #** **100 %**
Consumers/ Survivors/ Ex-patients (C/S/X)	**7**
Family Members of Children with SED	**7**
Family Members of Adults with SMI	**4**
Vacancies (C/S/X & family members)	**0**
Others (not state employees or providers)	**7**
Total C/S/X, Family Members & Others	**25 #** **62.5 %**
State Employees	**15**
Providers	**0**
Vacancies	**0**
Total State Employees & Providers	**15 #** **37.5 %**

Notes:
1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council. Percentage of family members of children with SED to total members = 7/40 = 17.5 %.

2) State employee and provider members shall not exceed 50% of the total members of the Planning Council. Percentage of state employees and providers 15/40 = 37.5 %.

3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support activities.

4) Membership is equally divided among the 10 Geographic Regions/ LGEs of the State, generally with two representatives from each Region/ LGE.

5) The council is committed to working towards diversity, and consideration is given towards representation of diverse groups in representation on the council.

Article I: NAME

The name of this organization shall be: *Louisiana Mental Health Planning Council* (herein: "council")

Article II: OBJECT

The object of the council shall be to serve the state of Louisiana as the mental health planning council provided for under 42 U.S.C. 300x-3 (State mental health planning council) and to exercise the following duties in connection therewith:

1. To review plans provided to the council pursuant to 42 U.S.C. 300x-4(a) by the state of Louisiana and to submit to the state any recommendations of the council for modifications to the plans;
2. To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and
3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.

Article III: MEMBERSHIP

Section 1. Statutory Requirements.

A. The council shall be composed of residents of the state of Louisiana, including representatives of:
   1. The principal state agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and the state agency responsible for the development of the plan submitted pursuant to title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*);
   2. Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
   3. Adults with serious mental illnesses who are receiving (or have received) mental health services; and
   4. The families of such adults or families of children with emotional disturbance.
   5. With respect to the membership of the council, the ratio of parents of children with a serious emotional disturbance to other members of the council is sufficient to provide adequate representation of such children in the deliberations of the council.

B. At least 50 percent of the members of the council shall be individuals who are not state employees or providers of mental health services.

Section 2. Classes of Membership.

Membership on the council shall be of two classes: Individual and Organizational.

1. Individual members shall be those persons who are not representatives of a state agency or a public or private entity.
2. Organizational members shall be those persons appointed from state agencies or a public or private entity.

Section 3. Composition.

A. The council shall be composed of not more than 40 members.
B. Members shall be those persons whose applications for membership are approved by the council.

Section 4. Term of Service.

A. Term of service for members shall be four years. A member who has served two consecutive terms shall not be qualified for membership until the lapse of one year. Ex officio members shall not be term limited.
B. In the event of the death, resignation,

removal, or loss of qualification for membership, the council shall fill the vacancy thus created with a properly qualified person to serve for the duration of the former member's term.

C. A member may be removed from the council by a majority vote with notice, a two-thirds vote without notice, or a majority of the entire membership.

Article IV: OFFICERS

Section 1. Officers.

Officers shall be a chairman, a vice chairman, and a secretary. The chairman and vice chairman shall be members of the council.

Section 2. Duties.

Officers shall perform the duties prescribed by these bylaws and by the parliamentary authority adopted by the council.

A. Chairman. The chairman shall preside at meetings of the council. The council, however, may suspend this provision and elect a chairman pro tempore at any meeting. The chairman shall appoint all standing and special committees except that nothing shall prohibit the council from appointing special committees on its own motion. The chairman may appoint persons who are not members of the council to serve on any committee the chairman is authorized to appoint. The chairman shall be ex officio a member of all committees except the nominating committee, and shall have such other powers and duties as the council may prescribe.

B. Vice chairman. The vice chairman shall serve as chairman of the committee on membership and shall perform such other duties as the council may prescribe. In the absence of the chairman from a meeting, the vice chairman shall preside unless the council elects a chairman pro tempore.

C. Secretary. The secretary shall be the custodian of the records of the council and shall keep or cause to be kept a record of the minutes of the meetings of the council. The secretary shall maintain an indexed book containing all standing rules adopted by the council. The secretary shall also be the custodian of the council seal, and shall attest to and affix said seal to such documents as may be required in the course of its business. The secretary may appoint an assistant secretary who shall be authorized to fulfill the duties under the direction and authority of the secretary.

Section 3. Nomination and Election.

A. The council shall elect officers at the regular meeting in the last quarter of each even numbered year.

B. At the regular meeting immediately preceding the election meeting, the council shall elect a nominating committee of three members. It shall be the duty of this committee to nominate candidates for the offices to be filled. The nominating committee shall report its nominees at the election meeting. Before the election, additional nominations from the floor shall be permitted.

C. In the event of a tie, the winner may be decided by drawing lots.

Section 4. Term of Office.

Officers shall serve for two years or until their successors are elected and assume office. Officers shall assume office at the end of the meeting at which they are elected.

Section 5. Removal from Office.

The council may remove from office any officer at any time.

Section 6. Vacancy.

A. In the event of a vacancy in the office of chairman, the vice chairman shall succeed to the office of chairman.

B. In the event of a vacancy in the office of vice chairman or secretary, the chairman

may appoint a temporary officer to serve until the council elects a replacement.

Article V: MEETINGS

Section 1. Regular Meetings.

Regular meetings of the council shall be held on the first Monday of the second month of each calendar quarter. The council may reschedule its next regular meeting at any regular or special meeting.

Section 2. Special Meetings.

Special meetings may be called by the chairman and shall be called upon the written request of a majority of the members. The purpose of the meeting shall be stated in the call.

Section 3. Notice of Meetings.

A. Notice of the hour and location of regular meetings, and notice of any change in the date, time, or place of any regular meeting shall be sent in writing to the members at least ten days before the meeting.

B. Notice of special meetings of the council shall be sent at least ten days before the date of the meeting. The notice shall state the purpose of the meeting. In the event the secretary fails to issue, within a reasonable time, a special meeting call on the request of members of the council, the members who petitioned for the call may schedule the special meeting and issue the call and notice at the expense of the council.

Section 4. Quorum.

A quorum shall consist of twelve members.

Article VI: COMMITTEES

Section 1. Executive Committee.

A. Composition. The chairman of the council shall be the chairman of the executive committee. The vice chairman, the secretary, and an OMH state block grant planner shall be members of the executive committee.

B. Duties and Powers. The executive committee shall, to the extent provided by resolution of the council or these bylaws, have the power to act in the name of the council. The executive committee shall fix the hour and place of council meetings, make recommendations to the council and perform such other duties as are specified in these bylaws or by resolution of the council. But, notwithstanding the foregoing or any other provision in these bylaws, the executive committee shall not have the authority to act in conflict with or in a manner inconsistent with or to rescind any action taken by the council; to act to remove or elect any officer; to establish or appoint committees or to name persons to committees; to amend the bylaws; to authorize dissolution; or, unless specifically authorized by a resolution of the council, to authorize the sale, lease, exchange or other disposition of any asset of the council, and in no event shall it make such disposition of all or substantially all of the assets of the council.

C. Meetings. The executive committee shall meet on the call of the chairman or the three other members. Notice of at least 24 hours shall be given for any meeting of the executive committee. Executive committee members may at any time waive notice in writing and consent that a meeting be held. The executive committee is authorized to meet via teleconference or videoconference provided that all members in attendance can hear each other. A quorum of the executive committee shall be a majority of its membership.

Section 2. Standing Committees.

A. The chairman of the council shall appoint the following committees:

1. Committee on Advocacy. The committee on advocacy shall report and recommend on matters involving the mental health advocacy program of the council.

2. Committee on Finance. The committee on finance shall report and recommend on matters affecting the mental health block grant funds and the council operating budget.
3. Committee on Membership. The committee on membership shall report and recommend on matters involving the membership recruiting and composition of the council.
4. Committee on Programs and Services. The committee on programs and services shall report and recommend on matters related to planning, development, monitoring, and evaluation of mental health programs and services in the state.

B. A state block grant planner shall be ex officio a member of each standing committee.

Section 3. Duties and Powers of Standing Committees.

The council shall establish such specific duties and authority for each standing committee as necessary to carry on the work of the council.

Section 4. Other Committees.

Such other committees, standing or special, may be appointed by the chairman or by the council as may be necessary to carry on the work of the council.

Article VII: PARLIAMENTARY AUTHORITY

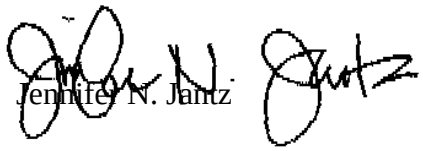
The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the council in all cases to which they are applicable and in which they are not inconsistent with these bylaws, any special rules of order the council may adopt, and any statutes applicable to the council that do not authorize the provisions of these bylaws to take precedence.

Article VIII: AMENDMENT

These bylaws may be amended at any council meeting by a two-thirds vote, provided that the amendment has been submitted in writing at the previous regular meeting or notice of the proposed amendment is mailed to the members at least 21 days but no more than 30 days before the meeting at which the proposed amendment is to be considered. Additionally, in the case of a special meeting, notice of the proposed amendment shall be included in the call.

CERTIFICATE

I, Jennifer N. Jantz, Chairman of the Louisiana Mental Health Planning Council, certify that the foregoing revised bylaws of the council are those adopted on November 5, 2007 at a regular meeting of the council.



Jennifer N. Jantz

STANDING RULES

MEMBERSHIP COMPOSITION

SECTION 1. NUMBER OF MEMBERS

The number of council members shall be 40.

SECTION 2. COMPOSITION OF THE COUNCIL

The membership composition of the council shall be as follows:

A. Organizational members

1. Appointed from state agencies

a. Two members from OMH responsible for the preparation of the block grant plan.

b. Six members from state agencies as mandated by federal law, one from each of the following:

(1) DHH Office of Mental Health (OMH)

(2) Louisiana Department of Education (LDE)

(3) DSS Louisiana Rehabilitation Services (LRS)

(4) Louisiana Housing Finance Agency (LHFA)

(5) Department of Social Services (DSS)

(6) Department of Public Safety and Corrections (DPS&C)

c. Four other members from state agencies as follows:

(1) DHH Bureau of Health Services Financing (Medicaid)

(2) DHH Office for Addictive Disorders (OAD)

(3) DHH Office for Citizens with Developmental Disabilities (OCDD)

(4) DHH Office of Public Health (OPH)

2. Appointed from mental health advocacy organizations:

Six members, one from each of the following:

(1) Meaningful Minds of Louisiana

(2) Louisiana Federation of Families for Children's Mental Health

(3) National Alliance on Mental Illness – Louisiana

(4) Mental Health America of Louisiana

(5) American Association of Retired Persons in Louisiana (AARP LA)

(6) The Extra Mile

3. Appointed from OMH regional advisory councils (RAC):

Ten members, one from each RAC.

B. Individual Members

Ten members, one from each OMH Region or local governing entity (LGE).

Two members from the state at-large.

SECTION 3. QUALIFICATIONS

Council members shall fall into one or more of the following categories in order to be considered qualified for service on the council:

1. Adults with serious mental illness who are receiving or who have received mental health services, or
2. Family members of adults with serious mental illness, or
3. Children and youth with serious emotional/behavioral disorders who are receiving or have received mental health services and related support services, or
4. Parents and family members of children/youth with a serious emotional/ behavioral disorder, or
5. Advocates for the severely mentally ill, or

6. Individuals, including providers, who are concerned with the need, planning, operation, funding, and use of mental health services and related support services.

Adopted November 5, 2007

NON-DISCRIMINATION POLICY

The council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy and parenthood, custody of a minor child, or physical, mental, or sensory disability.

Revised November 5, 2007

AUTHORIZED REPRESENTATIONS

1. The council may officially represent itself, but not the office of mental health, the state of Louisiana, any state agency, or any individual member in any matter concerning or related to the council.
2. No council member shall make representations on behalf of the council without the authorization of the council.

Revised November 5, 2007

COUNCIL AGENDA

1. The secretary shall prepare an agenda for each council meeting. Council members may submit motions in advance for placement on the agenda for consideration under the appropriate order of business. Officers and committees reporting recommendations for action by the council shall submit the recommendations to the secretary at least 10 days before the meeting for entry on the agenda. The tentative agenda for all regular meetings will be available to all council members at least five (5) days prior to each council meeting. The secretary shall distribute the tentative agenda in advance to any member who requests it by the method requested by the member.
2. Nothing contained in this rule shall prohibit the council from considering any matter otherwise in order and within its object at any regular meeting.

Revised November 5, 2007

SPECIAL RULES OF ORDER

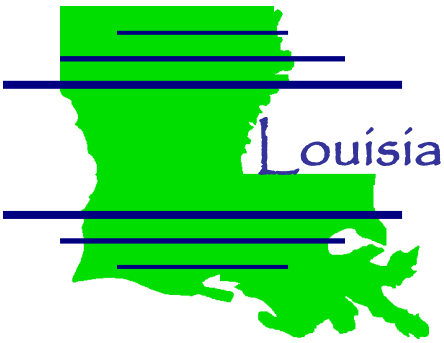
ADOPTED NOVEMBER 5, 2007

ATTENDANCE

At the first regular council meeting after the second consecutive absence of a council member, the executive committee shall report its recommendation on the question of retention or removal of the member from the council.

PUBLIC COMMENT

1. At any time the council considers a matter on which a member of the public wishes to address the council, the council shall make reasonable efforts to provide the opportunity to a representative number of proponents and opponents on each issue before the council.
2. Each person appearing before the council shall be required to identify himself and the group, organization, or company he represents, if any, and shall notify the chairman no later than the beginning of the meeting by completing a basic information form furnished by the secretary.
3. To be certain that an opportunity is afforded all persons who desire to be heard, the chairman shall inquire at the beginning of any period of public comment on each matter if there are additional persons who wish to be heard other than those who have previously notified the chairman.
4. Subject to such reasonable time limits the council may establish for any public hearing or period of public comment, the chairman shall allot the time available for the hearing in an equitable manner among those persons who are to be heard. In no case, however, shall any person speak more than five minutes without the consent of the council.



Louisiana Mental Health Planning Council

August 15, 2008

Ms. Barbara Orlando
Grants Management Officer
Division of Grants Management
OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

Dear Ms. Orlando:

The Louisiana Mental Health Planning Council (LMHPC) has been given an opportunity to review and comment on the Center for Mental Health Services (CMHS) Community Mental Health Services Block Grant Application for the fiscal year 2008-09. The quarterly meeting of the LMHPC was held on August 4, 2008. At this meeting, the membership participated in a formal review of the plan, and comments were welcomed. Feedback on the goals and activities of the Office of Mental Health was largely positive. The LMHPC membership was also informed that a draft of the 2009 Plan is available on the new LMHPC listserv, with instructions for submitting feedback on the plan.

The Office of Mental Health has made efforts to include LMHPC in all phases of the development and implementation of the plan. The members who serve on the Council and the committees of the Council have joined with OMH to forge a more relevant and meaningful partnership in which the voices of consumers and families are heard.

We as a Council believe that the plan is increasingly responsive to the needs identified in the *President's New Freedom Commission Report*, and serves as a guidepost in efforts to transform the mental health system in the state.

Sincerely,

Jennifer Jantz, Chair
Louisiana Mental Health Planning Council
Executive Director,
NAMI Louisiana

5700 Florida Boulevard, Suite 320
Baton Rouge, Louisiana 70806

LOUISIANA FY 2009
BLOCK GRANT PLAN

Part C
STATE PLAN
Section I

Adult & Child/ Youth

Description of the State Service System

SECTION I – DESCRIPTION OF STATE SERVICE SYSTEM
OVERVIEW, REGIONAL RESOURCES, LEADERSHIP
LOUISIANA FY 2009 - ADULT & CHILD/ YOUTH PLAN

INTRODUCTORY COMMENTS

No current discussion of Louisiana can take place without reflection on the tragedy and devastation experienced by the State in the form of Hurricanes Katrina and Rita in August - September of 2005. There is no question that the State of Louisiana and its people are forever changed as a result of these storms. While the city of New Orleans and the Gulf coast region sustained the most direct damage, the entire state continues to experience the repercussions of the disaster. Louisianians are by nature a resilient group, progress is being made, and there is much work still ahead; but it would be inaccurate to say that the state is anywhere near having recovered from the crisis. As stated in the *President's New Freedom Commission on Mental Health Report*:

Recovery is the Goal of a Transformed System.

In the aftermath of the hurricanes, it was necessary to re-evaluate goals, targets and indicators that had been previously established. In general, Block Grant goals have remained, but Targets and Indicators were initially readjusted to realistically reflect the capabilities of a strained and in some cases an incapacitated system. Many activities were reorganized and resumed as quickly as possible, but the impact on services was unavoidable, and often unpredictable.

Specific post-hurricane modifications were made to the FY 2006 Plan based on very preliminary predictions, but it is noted that the predictions were often based on very little *real data* and targets were set on estimates based on information that was at best, incomplete. The FY 2007 and 2008 Plans were somewhat improved in the ability to predict the capacity of the state mental health system, as things began to stabilize. In collaboration with the Planning Council, attempts have been made to set the post-hurricane targets in a conservative, yet realistic manner; however, the expectation all along has been that services would continue to be offered at the highest possible level. The state has only now begun to re-establish many baselines from which to work. As a very concrete example, the population of the state decreased as a result of the exodus of evacuees after the hurricanes. Even three years later not all of these individuals have returned, and it is not known if they will return, where they will relocate, or when. Further, it is difficult to get accurate accountings of population figures for the various geographic areas of the state at all.

The full extent of the storm's impact on the OMH budget, services, operations, and data collection/ reporting capacity will not truly be determined in the short term. The fiscal realities that Louisiana will experience long term are simply not predictable with any measure of certainty.

At least three major effects on the system initially had widespread consequences on the ability to carry out needed reforms and improvements, and on the ability to measure the State's progress in reaching goals. Although certainly not completely eliminated, steady progress has been made towards alleviating these problems that include the difficulties described below:

- Reduced ability to access and measure progress towards goals, as a result of reductions in the capabilities of data collection and interpretation by the information technology division.

- Damaged and destroyed clinics and hospitals eliminated the infrastructure needed to provide services.
- Reductions in workforce and less service capability resulted from initial statewide budget deficits and out-migration of professional staff.

In the last three years, the people of Louisiana have seen examples of the varied and courageous efforts that have been undertaken by consumers and OMH staff members to assist others following the storms. While initially, the news often highlighted the horror of the storms, along with negative stereotypes, there are many more stories of *people (including consumers) simply helping people*, regardless of their station in life, and not seeking recognition or reward.

This aftermath of the disaster has truly shown that the strength of the Louisiana mental health system lies in the committed workforce. Many individuals employed by OMH have given generously of their time and energy to ameliorate the state of affairs that many Louisiana citizens have found themselves in. The needs and priorities of the service system to respond to Hurricane Katrina and Hurricane Rita necessarily shifted both fiscal and human resources to respond to the crisis. The crisis and the recovery from the crisis will affect the delivery of mental health care for an indefinite period of time. Fortunately, we do believe in the principle that *people recover*. The FY 2009 Block Grant Application is presented in the context of, and with an awareness of the aftermath of the storms. It is impossible to discuss most areas of the plan without reference to the effects of the storms and the legacy that Katrina and Rita have left for the State and its citizens.

OVERVIEW OF MENTAL HEALTH SYSTEM IN LOUISIANA

The Office of Mental Health (OMH) operates within the Department of Health and Hospitals (DHH) alongside agencies of the Office of Public Health, the Office for Addictive Disorders, the Office for Citizens with Developmental Disabilities, the Office of Management and Finance (including the State Medicaid agency), and the recently created Office of Aging and Adult Services. The Office of Mental Health is governed by the Assistant Secretary (e.g., Commissioner) of Mental Health who is the appointing authority for the agency, and reports to the Secretary of the Department of Health and Hospitals.

In order to assist the reader in understanding the State mental health care system, a map of Louisiana that illustrates the geographic Areas/ Regions/ LGEs, and organizational charts of OMH and DHH are included in this section. It should be noted that the Mental Health Planning Council occupies a prominent place in the formal OMH organizational chart. In 2004, funding allowed for a new staff position to act as liaison between the Planning Council and OMH. Strategic planning ensures that the goals and objectives of the OMH and the plans for transformation are carried out according to the *President's New Freedom Commission Report*.

State Agency Leadership & Description of Regional Resources

The Office of Mental Health (OMH) is the state agency currently responsible for planning, developing, operating, and evaluating public mental health services for the citizens of the State. The Office of Mental Health services are targeted to adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, and all people experiencing an acute mental illness. While there is no separate state-wide division for Children's services, the Division of *Child / Youth Best Practices* occupies a prominent position in the functioning of the Office of Mental Health as is noted within the organizational chart. Regions and LGEs are required to

maintain Regional Advisory Councils officially linked to the State Planning Council in order to receive Block Grant funding.

To enhance administrative efficiency, OMH historically had divided the State into three formal service *Areas*: Areas A, B, & C. Each Area, inclusive of one or more parishes, consisted of at least one state hospital, and a collection of community mental health centers that operated within the structure of a *Region* as a subset of the Area structure. Legislation has mandated that the administration of the Louisiana mental health care system change from interrelated geographic *Regions* to a system of independent health care Districts or Authorities (also referred to as *Local Governing Entities or LGEs)* under the general administration of OMH. As of July, 2008, there are six of the original ten Regions that continue to operate as Regions; while the remainder of the state consists of LGEs. Regions are evaluating their readiness to become LGEs, and the transition to LGEs is expected to be complete by the year 2011. With the trend towards more LGEs comes the importance of developing mechanisms to assure continuity of care and consistency of statewide standards of care that are responsive to needs of consumers.

In the past, the Community Mental Health Center (CMHC) and State Hospital programs were all directly operated by state civil servants with direct line of authority from the OMH central office. The LGEs are (and will be) legislatively mandated as the local umbrella agencies that administer the state-funded mental health, addictive disorder and developmental disability services in an integrated system within their localities. The LGE model affords opportunity for greater accountability and responsiveness to local communities since it is based on local control and local authority. Each LGE is administered by an Executive Director who reports to a local governing board of directors of community and consumer volunteers. All local governing entities remain part of the departmental organizational structure, but not in a direct reporting line with OMH. The Office of Mental Health maintains requirements for uniform data reporting through memoranda of agreement arrangements supported by the Department of Health and Hospitals. With the transition to local governing entities, the role of the Office of Mental Health will also transition to provide resources and assistance that enables the LGEs to carry out service delivery. In addition, OMH will ensure that the LGE service system is well coordinated with those services that will continue to be operated by the State (primarily the State-operated psychiatric hospitals). OMH will also be responsible for providing assistance in setting policy, establishing minimum standards for the operation of the service system, establishing reasonable expectations for service utilization and outcomes, and developing mechanisms statewide for measuring outcomes. With the trend towards more local governing entities comes the importance of developing mechanisms to assure continuity of care and consistency of standards of care that are responsive to needs of consumers. Legislation has established roles and accountability mechanisms for DHH's relationship with LGEs.

The first local Governing Entity, the Jefferson Parish Human Service Authority, has operated all public mental health, substance abuse, and developmental disability services for that parish since 1989. A second LGE, the Capital Area Human Service District, was authorized by the legislature in 1998. This LGE includes several parishes, and integrates mental health, substance abuse, developmental disability, and public health services in one regional system of care. Two new LGEs became operational in July of 2004, the Florida Parishes Human Services Authority and the Metropolitan Human Services District. Two more LGEs are evaluating their readiness and preparing to become operational, the Northeast Delta Human Services Authority (Region 8) and the South Central Louisiana Human Services Authority (Region 3).

The capacity for service delivery within the State continues to recover from the devastation brought on by Hurricanes Katrina and Rita in 2005. Two clinics in the New Orleans area remain closed as a result of damage associated with of the storms. There are currently a total of 43 Community Mental Health Centers and Clinics (CMHCs), and 27 Outreach Clinics that are operational in the State. The CMHCs provide an array of services including crisis services, screening and assessment, individual evaluation and treatment, psychopharmacology, clinical casework, specialized services for children and youth, and in some areas, specialized services for those in the criminal justice system and for persons with co-occurring mental and substance disorders. OMH also provides additional community-based services either directly or through contractual arrangements, including supported living, supported employment, family/ consumer support services (e.g., case management, respite, drop-in centers, consumer liaisons), and school-based mental health services. OMH (including the LGEs) has over 115 contracts with private agencies, funded by the Block Grant to provide a wide array of additional community-based services. OMH operates as a managed care agent of the state Medicaid agency to authorize and monitor quality and outcomes for mental health rehabilitation services operated through private Medicaid provider agencies statewide.

There are four state-operated intermediate/long term inpatient care psychiatric hospitals that have a total of 810 Intermediate care beds: Southeast Louisiana Hospital in Mandeville, Eastern Louisiana Mental Health System in Jackson and Greenwell Springs, New Orleans Adolescent Hospital, and Central Louisiana State Hospital in Pineville. Three of these hospitals serve children and youth; and one hospital includes a division that is solely designated for the treatment of the forensic population. New Orleans Adolescent Hospital in New Orleans historically has treated solely children and adolescents. In response to the loss of bed capacity in New Orleans due to the hurricanes, the New Orleans Adolescent Hospital (NOAH) was modified to include 30 adult acute beds. Fifteen beds remain dedicated to children and adolescents at NOAH. There are also currently a total of eight facilities in the state that are operated by the Louisiana State University Medical schools that have acute mental health beds. The total number of acute beds is 283.

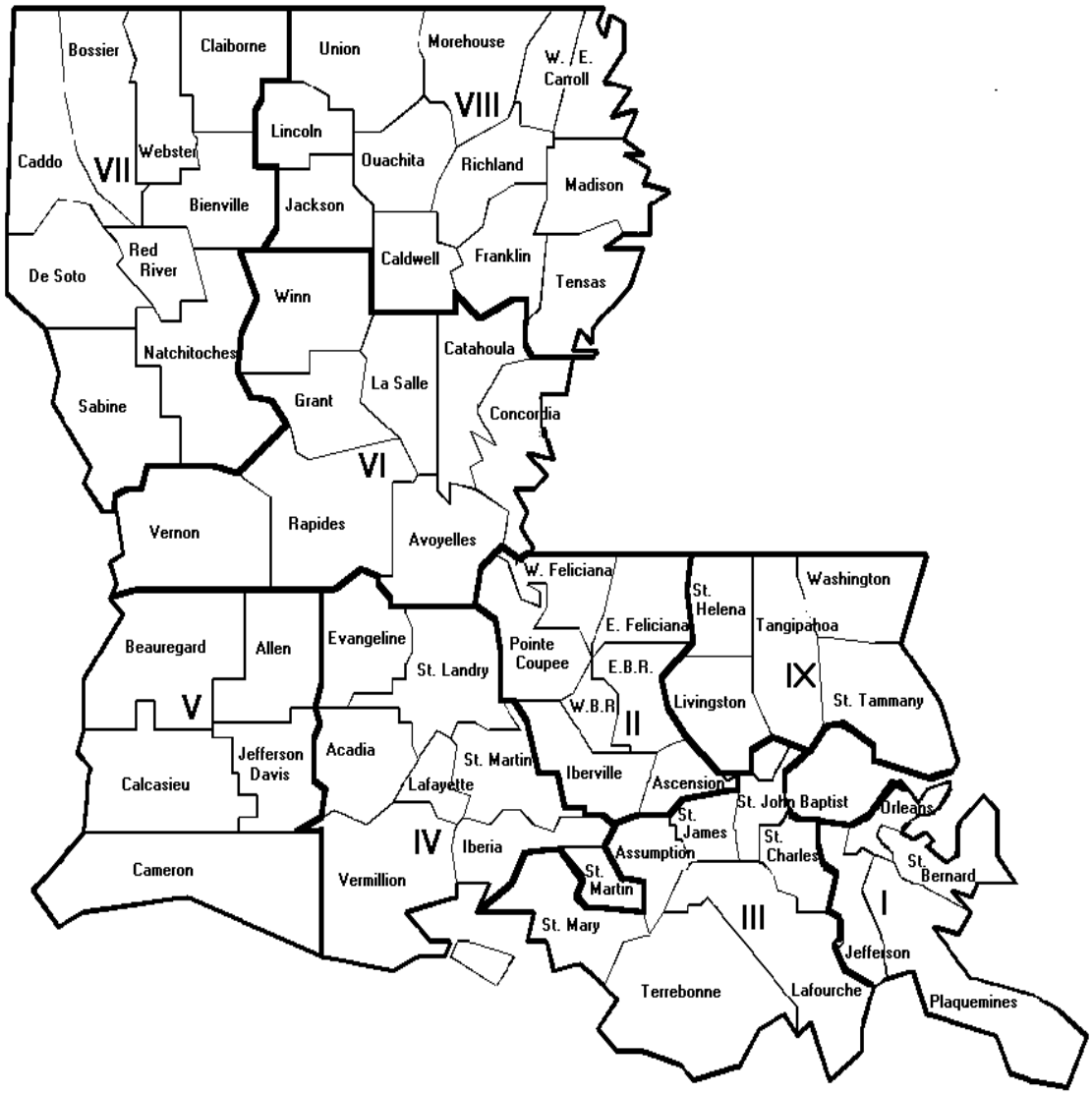
OMH provides for a regional single point of entry (SPOE) process to facilitate access to acute and/or intermediate/ long-term hospital placements. However, the demand for available inpatient services continues to exceed the number of available hospital beds due to in part to infrastructure changes that unavoidably occurred following the 2005 hurricanes (Katrina and Rita). Prior to the hurricanes, there were a total of 841 inpatient beds including 19 child beds; 77 adolescent beds (of which 25 were developmental neuro-psychiatric program beds); and 235 specialty forensic beds. Of the 841 beds, 439 beds were HCFA certified. Due to the loss of Charity Hospital in New Orleans, there were 97 adult acute inpatient beds lost in the New Orleans area, but equally importantly, the city of New Orleans lost 372 psychiatric beds for adults, children adolescents, geriatrics and/or substance abuse.

In keeping with System of Care principles and the need for a comprehensive continuum of care, the Office of Mental Health has improved the array of community based services operated through the hospitals and geographic Regions. Persistent efforts have been successful in establishing more community-based services operated through the hospitals (e.g., day hospitals, rehabilitation programs). The community and hospital system of care emphasize continuity of care and treatment in the least restrictive environment appropriate to the person's needs. There is an emphasis on a close liaison between the regional service system, the LGEs, state hospitals, community provider agencies, and consumer and family support and advocacy systems. OMH supports consumer and family involvement in the planning, development, delivery, and evaluation of services. OMH

provides funding for regional consumer drop-in centers, psycho-social clubhouses, and Regional consumer liaisons. OMH also trains and employs consumer and family members and parents of emotionally disturbed children as quality of service evaluators. OMH has developed a Vision and Mission that guide the administration and day-to-day provision of services.

Statewide planning and development towards a comprehensive, community-based system of care is guided through the efforts of the State Mental Health Planning Council originally established under PL 99-660 guidelines with full consumer/ family representation from throughout the State. The Planning Council is responsible for Block Grant planning, together with OMH staff dedicated to this function. The membership of the Planning Council includes 40 members who are primary consumers, family members, parents of children with emotional/ behavioral disorders, advocates, Regional Advisory Council chairs, and human service agency (LGE) representatives. The council is geographically representative of the state. Included within the Council governance is the Programs and Services Committee that addresses matters related to planning, development, monitoring, and evaluation of mental health programs and services in the state. The OMH consumer survey process, C'est Bon, and the C/Y family survey process, La Fete, were developed by and are monitored by this committee of the Council. The Planning Council and consumers have been very active in service system performance evaluation.

Readers are referred to the State Map and Organizational Charts, and tables that are provided in this section.



OMH AREAS, REGIONS & LOCAL GOVERNING ENTITIES

Area A = Regions: I (MHSD[a]), III [b], IX (FPHSA[c]), X (JPHSA[d])
Area B = Regions: II (CAHSD[e]), IV, V
Area C = Regions: VI, VII, VIII[f]

[a] Metropolitan Human Services District = Region I
[b] Region III ***(will become South Central Louisiana Human Services Authority)***
[c] Florida Parishes Human Services Authority = Region IX
[d] Jefferson Parish Human Services Authority = Region X
[e] Capital Area Human Services District = Region II
[f] Region VIII ***(will become Northeast Delta Human Services Authority)***

(See accompanying text for a full description of *Area, Region and Local Governing Entities*)

MENTAL HEALTH CENTERS, CLINICS AND OUTREACH CLINICS (7/2009)

MHSD (Region 1)	Location / Status
Chartres-Pontchartrain Behavioral Health Clinic	New Orleans
St. Bernard Behavioral Health Clinic	St. Bernard
Central City Behavioral Health Clinic	New Orleans
New Orleans East Behavioral Health Clinic	New Orleans East
Plaquemines Behavioral Health Center	Belle Chase
Algiers-Fischer Outreach	Algiers
Desire Florida Mental Health Clinic	***Closed*** *due to hurricane*
St. Bernard Mental Health Clinic	***Closed*** *due to hurricane*
CAHSD (Region 2)	
Baton Rouge Mental Health Center	Baton Rouge
Gonzales Mental Health Center	Gonzales
Margaret Dumas Mental Health Center	Baton Rouge
Clinton Outreach	Clinton
Donaldsonville Outreach	Donaldsonville
New Roads Outreach	New Roads
Plaquemine Outreach	Plaquemine
Port Allen Outreach	Port Allen
St. Francisville Outreach	St. Francisville
REGION 3	
Terrebonne Mental Health Center	Houma
Lafourche Mental Health Center	Raceland
South Lafourche Mental Health Center	Galliano
River Parishes Mental Health Center	LaPlace
St. Mary Mental Health Center	Morgan City
Assumption Mental Health Clinic	Labadieville
Lutcher Outreach	Lutcher
Vacherie Outreach	Vacherie
REGION 4	
Dr. Joseph Henry Tyler MH Center	Lafayette
New Iberia Mental Health Center	New Iberia
Opelousas Outreach Clinic	Opelousas
Crowley Mental Health Center	Crowley
Ville Platte Mental Health Center	Ville Platte
Abbeville Outreach	Abbeville
St. Martinville Outreach	St. Martinville
Eunice Outreach	Eunice
Kaplan Outreach	Kaplan
Church Point Outreach	Church Point
Mamou Outreach	Mamou
REGION 5	
Lake Charles Mental Health Center	Lake Charles
Allen Mental Health Clinic	Oberlin
Beauregard Mental Health Clinic	DeRidder

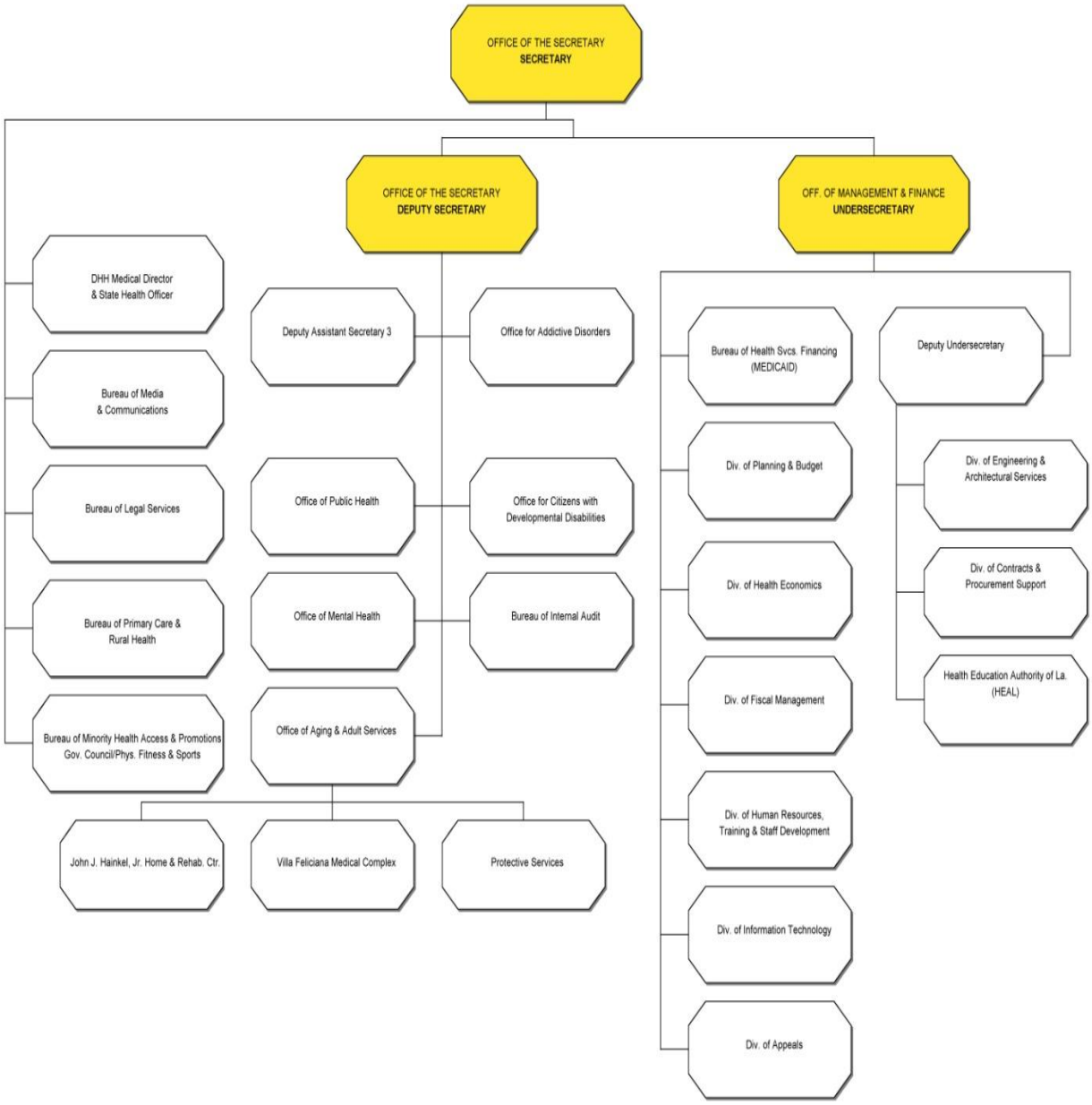
REGION 6	
Mental Health Center of Central LA.	Pineville
Leesville Mental Health Center	Leesville
Avoyelles Mental Health Center	Marksville
Jonesville Outreach Clinic	Jonesville
Bunkie Outreach	Bunkie
Winnfield Mental Health Outreach	Winnfield
Simmsport Outreach	Simmesport
REGION 7	
Shreveport Mental Health Center	Shreveport
Minden Mental Health Clinic	Minden
Natchitoches Mental Health Center	Natchitoches
Mansfield Mental Health Clinic	Mansfield
Many Mental Health Clinic	Many
Red River Mental Health Clinic	Coushatta
Arcadia Outreach	Arcadia
Logansport Outreach	Logansport
REGION 8	
Monroe Mental Health Center	Monroe
Richland Mental Health Clinic	Rayville
Tallulah Mental Health Clinic	Tallulah
Ruston Mental Health Center	Ruston
Jonesboro Mental Health Center	Jonesboro
Columbia Outreach (& Winnsboro Clinic- merged)	Columbia
Bastrop Mental Health Clinic	Bastrop
Farmerville Outreach	Farmerville
Delhi Outreach	Delhi
Lake Providence Outreach	Lake Providence
Oak Grove Outreach	Oak Grove
St. Joseph Outreach	St. Joseph
FPHSA	
Lurline Smith Mental Health Center	Mandeville
Bogalusa Mental Health Center	Bogalusa
Rosenblum Mental Health Center	Hammond
Slidell Mental Health Outreach	Slidell
JPHSA	
East Jefferson Mental Health Center	Metairie
West Jefferson Mental Health Center	Marrerro

HOSPITALS

Central Louisiana State Hospital	Pineville
Eastern Louisiana Mental Health System – Greenwell Springs Division	Greenwell Springs
Eastern Louisiana Mental Health System – Forensic Division	Jackson
Eastern Louisiana Mental Health System – East Division	Jackson
New Orleans Adolescent Hospital	New Orleans
Southeast Louisiana Hospital	Mandeville

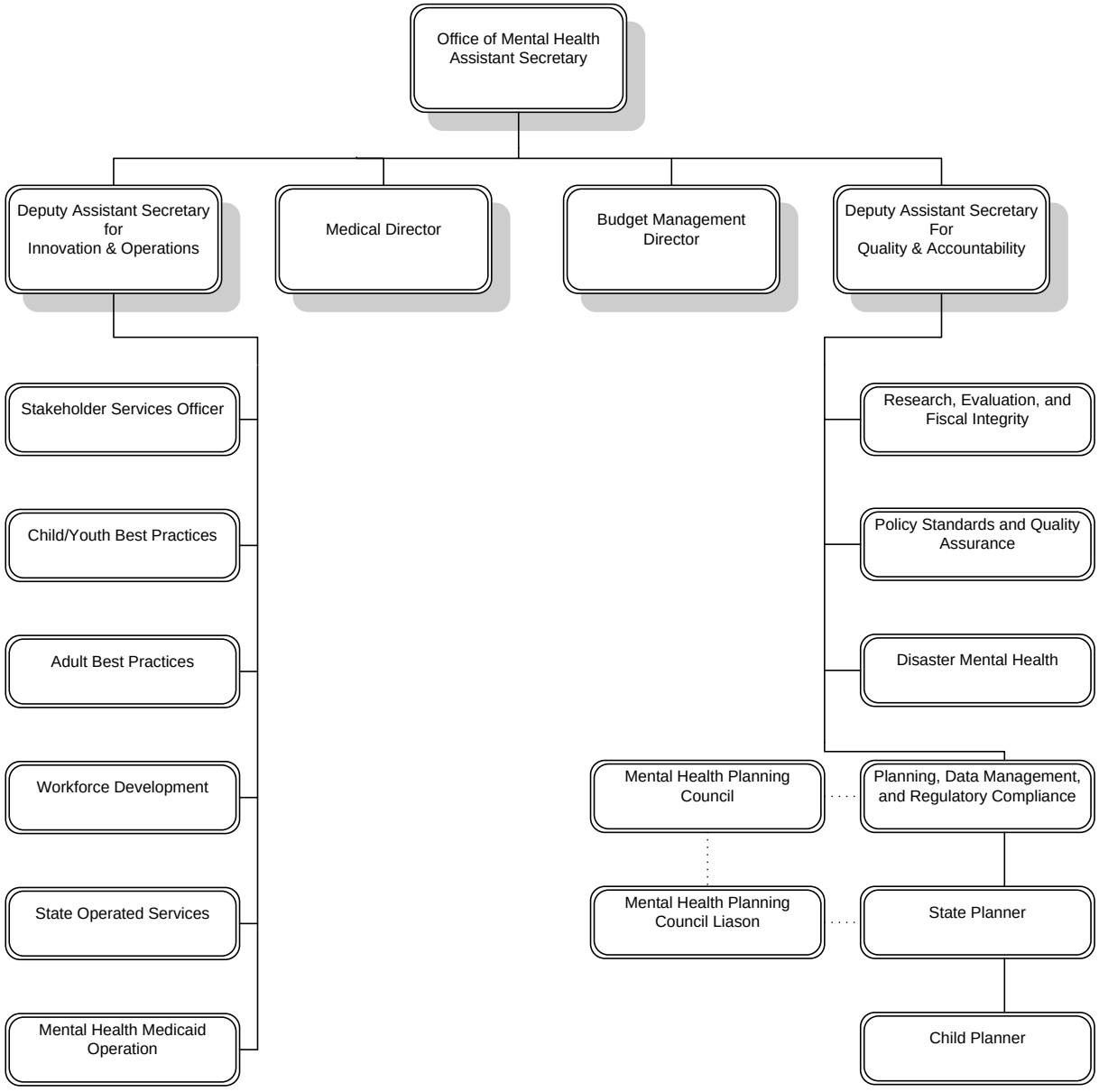
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

May 2007



Office of Mental Health

Organizational Chart
July 2008 *(Provisional)*



SECTION I – DESCRIPTION OF STATE SERVICE SYSTEM
SUMMARY OF AREAS IDENTIFIED AS NEEDING ATTENTION
LOUISIANA FY 2009 - ADULT & CHILD/ YOUTH PLAN

Louisiana has long had a fragmented mental health system and access to care has historically been inadequate. Available services often do not reflect best practices or evidence based practices. Hurricanes Katrina and Rita further diminished the State's capacity to provide services, while at the same time, the need for services increased. Services have slowly returned in some areas, or are available at a reduced level due to the many problems that accompanied the hurricanes of August and September of 2005, including problems in infrastructure, staffing, and funding.

Prior to the storms, there was widespread recognition of the need to transform Louisiana's mental health systems. In June, 2005, Louisiana Governor Kathleen Blanco issued an Executive Order titled "Louisiana's Plan for Access to Mental Health Care." DHH was named lead agency and as a first step engaged the Behavioral Health Policy Collaborative and the Technical Assistance Collaborative to conduct an extensive programmatic review of Louisiana's mental health systems and services. The ensuing report, published in June, 2006, identified inadequate areas and provides specific recommendations and a roadmap for transformation. The Report's fifteen areas of focus include the following:

- Vision and Mission;
- Leadership;
- Service Delivery Structures and Relationships;
- Organization and Role of Office of Mental Health;
- Financing;
- Evidence-Based Practices;
- Acute Care/Crisis Network Response;
- Suicide Prevention and Response;
- Cultural Competence and Eliminating Disparities;
- Workforce Development;
- Children/Youth/Families;
- Primary Care Integration;
- Homelessness and Housing;
- Employment;
- Criminal Justice.

For a more detailed description of these focus areas, the current status of the Governor's Plan, and current reform efforts, the reader is referred to *Part C, Section II, Identification of the Service System's Strengths, Needs, and Priorities*.

NEW DEVELOPMENTS AND ISSUES AFFECTING MENTAL HEALTH DELIVERY FOR FY 08-09

Nearly three years ago, two major hurricanes left unprecedented damage and destruction in the State of Louisiana, affecting the lives and livelihoods of all Louisiana citizens. Hurricanes Katrina and Rita necessitated reevaluation of the goals of the Office of Mental Health (OMH) and reassignment of some staff members to more immediate and urgent needs, while continuing to ensure that services to the individuals served by OMH were not disrupted. These efforts involved necessary redeployment of human and fiscal resources to address immediate and longer-term needs for crisis response, recovery and planning. Disruption in operations of services, facilities and administrative functions at both the state and local levels occurred; most of which have been resolved, yet some disruption continues to impact the service system. Slow but steady progress is being made at recovering and revamping the service system, but there is still much work to do.

Services in the hardest hit areas (in the coastal regions, New Orleans, and the areas north of Lake Pontchartrain) were significantly impacted by the storms, causing much interference in, and in some cases elimination of, typical services and operations. Due to the evacuations from the coastal zones, the storms had a great impact on the entire state. Communities reported population increases of up to 100% from their normal census almost overnight in some cases. Although today this in- and out-migration has slowed, there is still movement, accompanied by disagreement about census figures among officials. Some families are just now receiving assistance to rebuild their homes in New Orleans, and others have decided to leave the city for good. The local community mental health programs have attempted to flex with the needs of the communities, but some serious problems remain.

Disaster mental health interventions including outreach and education for various individuals and groups, disaster survivors, their families, local government, rescuers, disaster service workers, business owners, religious groups and other special populations have been a part of the *Louisiana Spirit* Hurricane Recovery program. This program continues today and is fully described in Criterion 1 of Section III

Fund Development

The Fund Development division under the auspices of the Office of Mental Health facilitates and supports technical assistance in the pursuit of grant funding that further the agency's mission. Grant funds received from governmental agencies have provided the agency, its staff and the community with additional program opportunities not funded through the legislative appropriation for Louisiana's Office of Mental Health. The following overview of the 2007-2008 fiscal year provides information about numerous continuation awards.

Continuation Awards

- Louisiana Partnership for Youth Suicide Prevention, an award totaling $1,200,000 for a three-year funding period is currently in its final year. Since 2007, more than 2,139 youth and families have received direct programmatic services through a system of gatekeeper training, teen screenings, state advisory board meetings, area coalition meetings, safe talk, youth health summits, and statewide awareness activities with the goal of reducing the incidence of suicide in Louisiana.
- LA Spirit, a series of FEMA/SAMHSA service grants through the Federal Emergency Management Agency and administered by the Substance Abuse and Mental Health Services Administration, Center for Mental Health is in its final phases. The Office of Mental Health was awarded a federal grant for the Crisis Counseling Assistance and Training Program (CCP) in Louisiana which focuses on addressing post hurricane disaster mental health needs and other long-term disaster recovery initiatives, in coordination with other state and local resources. As of July, 2008, Louisiana has been awarded $19,537.929 for the Immediate Services Program and another 70,847,621 for the Regular Services Program. The Louisiana Spirit program will be ending December 31, 2008. This has been one of the longest FEMA funded crisis counseling programs, following a disaster. More detail about this project can be found in Section III, Criterion 1.
- The Lafayette Jail Diversion Project – Target Capacity Expansion Grant is a $1.2 million three year grant funded by the Substance Abuse and Mental Health Services Administration. The grant funds implementation of a post-booking jail diversion program with condition of release, utilizing the Lafayette Sheriff's Department as the central diversion point for project participants.
- Alternative to Restraint and Seclusion - The Office of Mental Health was awarded continuation funding for its fourth year for the Alternatives to Restraint and Seclusion project from SAMHSA to Build Capacity for Alternatives to Restraint and Seclusion; the project is to end in September 2008. This project has focused heavily on continuing improvement efforts on staff training, education, and evaluation to promote practices in the prevention of seclusion and restraint use with children and adolescents placed in inpatient psychiatric treatment facilities. In collaboration with the National Technical Assistance Center (NTAC) and multiple other local, state, and national agencies and consultants, trainings had been provided on trauma informed care, cultural sensitivity, crisis management skills without the use of physical intervention and family-professional partnerships and family sensitivity-inclusion at each facility (SELH and CLSH) to only name a few. Although NOAH was released from the requirements of the grant following Hurricane Katrina, facility staff and patients have continued to be included in ongoing trainings. There has been substantial progress made in the development of core strategies and intervention tools, cultural changes, and revisions of policies, procedures, and philosophy. The greatest improvement has been in restraint reduction with an approximate 75% of the goals achieved. The total funding for the 2004 - 2007 (2008) project period was $610,000.
- Louisiana Youth Enhanced Services for Mental Health (LA YES) is a continuing "cooperative agreement" that is now in its sixth year of funding from SAMHSA totaling $9.5 million dollars. This initiative provides services in five Southeast Louisiana Parishes (in the New Orleans area). Sustainability efforts continue with strategies to collaborate with child-serving partner agencies including the LGEs.

SECTION I – DESCRIPTION OF STATE SERVICE SYSTEM
LEGISLATIVE INITIATIVES & CHANGES
LOUISIANA FY 2009 - ADULT & CHILD/ YOUTH PLAN

LEGISLATIVE INITIATIVES AND CHANGES

Widespread changes in Louisiana's state government took place at the beginning of the 2008 calendar year. Numerous legislators were term-limited out of office, creating a climate of change in the legislature. Louisiana's new Governor, Bobby Jindal, took office promising sweeping reforms in both Ethics and Health Care, and included new initiatives for improving mental health care services. A record number of bills (2,989) were filed in the 2008 Regular Session of the legislature, 733 of which were relevant to health care. Of these, 31 bills were requested by DHH, including ten bills that were included in the Governor's package.

The 2008 Louisiana Legislature continued several efforts initiated in earlier sessions, including the reform of the juvenile justice program for Louisiana youth involved in the court system.

- HCR 0005 was established in the 2006 regular session to continue the study of issues relating to *juvenile competency* by creating a task force and extended the period of time for study. The resolution requests the House Committee on Administration of Criminal Justice and the Senate Committee on Judiciary B to meet and function as a joint committee to study and recommend policy directives for the state of Louisiana regarding these and other issues related to juvenile competency. Issues still being researched are the process of competency determination, restoration, and mental health intervention; recommendations for a plan of statewide implementation; and determination of the cost of implementation. It requests input from the Assistant Secretary of the Office of Mental Health. The Louisiana State Law Institute's Subcommittee on the Children's Code continues to meet and develop reforms.
- HB 503 was established in the 2006 regular session and is broad sweeping legislation enacted as a result of the work of the above mentioned task force and the Louisiana State Law Institute Subcommittee on the Children's Code. The Department of Health and Hospitals is in the process of revising and further developing rules and regulations for the training of *juvenile competency restoration providers* who are licensed by their respective state boards and are employed with DHH. Training for private providers from the community is being planned, and will be scheduled in the near future. To remain certified, a restoration provider must complete additional training every two years. The training module is patterned after national best practices and continues to be updated and revised. DHH maintains a master list of qualified providers and is making this list available on the Office of Mental Health website.

Other important legislation initiated this year or continued from previous years is referenced as follows:

- HB 1 of the 2008 regular session is the general *appropriations* bill. It provides for the ordinary operating expenses of state government including the Office of Mental Health.
- ACT 373 of the 2008 regular session provides relative to *human services districts*, and relative to the Capital Area Human Services District, including the powers, duties, and functions of the districts, its governing board and nomination procedures, reporting duties, and the transfer of powers, duties, functions, and employees from the Department of Health and Hospitals to the

districts; it provides for the reversion of the functions of human services districts to the Department of Health and Hospitals in the event of the termination of a contract; it creates statewide human services delivery systems; establishes the jurisdiction of human services districts; creates governing boards and provides for the appointment of board members, their terms, and compensation; establishes requirements for existing and newly created boards; provides for the powers, duties, and functions of the districts; provides for the transfer of certain powers, duties, and functions from the Department of Health and Hospitals to the districts; provides for transfer of employees; provides relative to the membership, responsibilities, and duties of the Human Services Interagency Council; establishes the duties and responsibilities of the Department of Health and Hospitals; and provides for the event of a conflict with other laws.

- ACT 407 of the 2008 regular session, *Assistive Outpatient Treatment/ Nicola's Law (outpatient commitment)* provides for involuntary outpatient treatment for behavioral health services; provides for criteria for involuntary outpatient treatment; provides for judicial procedure; provides for an order of custody; provides for a written treatment plan; provides for an appeal.
- SB 228 of the 2008 regular session provides relative to *crisis receiving centers*; provides for a crisis response system; provides for definitions; provides for licensing; provides for rules and regulations; provides for penalties.
- ACT 153 of the 2008 regular session (*emergency commitment via telemedicine*) provides relative to mental health admissions by emergency certificate; allows for the actual examination of a patient conducted by a health care provider, parish coroner, or authorized physician to be conducted by telemedicine utilizing video conferencing technology; and makes certain requirements for telemedicine examinations; provides for procedures related to the issuance of a certificate; requires an in-person independent examination by the coroner in certain cases.
- HB193 of the 2008 regular session provides for *medical malpractice* coverage for physicians who offer voluntary telemedicine services for the state.
- HCR155 of the 2008 regular session (*Civil commitment procedures for sexual predators*) provides, urges and requests the Department of Health and Hospitals to study the development and implementation of civil commitment procedures for the treatment of sexually violent predators and child sexual predators.
- SB 474 of the 2008 regular session *(Civil commitment of forensic patients)* adjusts time frame for forensic evaluation of adults. It provides relative to mental capacity to proceed to trial in criminal cases; provides with respect to the burden of proof regarding mental capacity determinations; provides for procedure after determination of mental capacity; requires that certain criteria be satisfied; repeals provisions authorizing the release of a defendant on probation.
- HB 1385 of the 2008 regular session relative to reimbursement for mental health services; creates the *Mental Health Access Committee*; provides for the membership, functions, and duties of the committee; provides for the study of a revised reimbursement methodology and standards of participation for community mental health clinics; provides for the promulgation of rules and regulations; provides for Medicare-certified community mental health centers and community mental health clinics. The Department of Health and Hospitals shall not enroll any new community mental health clinics until final rules and regulations are adopted in accordance with the Administrative Procedure Act pursuant to this Part.
- HR 102 of the 2008 regular session directs the Department of Health and Hospitals to study whether it is feasible to contract with a private contractor to provide forensic psychiatric services for any new forensic beds created and to report its findings to the House and Senate committees on health and welfare no later than February 1, 2009.

- SCR 78 of the 2008 regular session states that the Legislature of Louisiana does hereby support the creation of a *Joint Legislative Substance Abuse and Mental Health Caucus*.
- SCR 40 (*Electronic Medical Records*) provides for the study of the feasibility of the use of electronic medical records for certain persons with mental illness.
- ACT 447 (*Crisis Identification and Stabilization Services/ Receiving Centers*) provides for the development of regional crisis centers and a Regional Crisis Response System designed by a local collaborative including members from the community: local providers of mental health, substance abuse and developmental disabilities, the coroner's office, local EMS system, law enforcement, consumers, advocates, and public and private hospital emergency departments. The feasibility of a state-wide call center for crisis calls will be studied. The framework for this legislation will be built upon the Mental Health Access to Care State Plan established by the prior administration.
- HCR 184 (*Access to Mental Health Care continuation*) Creates a mental health care improvement task force. Task force includes DHH Secretary, President of LSU System, Chair of Louisiana Mental Health Planning Council, Assistant Secretary of OMH, Executive Director of Mental Health America of Louisiana (or designees).

LOUISIANA FY 2009
BLOCK GRANT PLAN

Part C
STATE PLAN
Section II

Adult & Child/ Youth

IDENTIFICATION & ANALYSIS
OF THE SERVICE SYSTEM'S STRENGTHS NEEDS
& PRIORITIES

SECTION II – IDENTIFICATION & ANALYSIS OF SERVICE SYSTEM'S STRENGTHS, NEEDS, & PRIORITIES

SERVICE SYSTEM'S STRENGTHS & WEAKNESSES

LOUISIANA FY 2009 - ADULT & CHILD/ YOUTH PLAN

The response to Hurricanes Katrina and Rita has shown that the strength of the Louisiana mental health system lies in the dedication and commitment of the workforce. Many individuals employed by the Office of Mental Health have given generously of their time and energy to ameliorate the state of affairs that many Louisiana citizens have found themselves in. The needs and priorities of the service system to respond to Hurricane Katrina and Hurricane Rita have necessarily shifted both fiscal and human resources to respond to the crisis. The crisis and recovery from the crisis continue to affect the delivery of mental health care, and will for an indefinite period of time. Louisiana workers have toiled endlessly to re-establish the infrastructure and systems to provide mental health care to Louisiana citizens.

A Roadmap for Change:
Bringing the Hope of Recovery to Louisianians with Mental Health Conditions

Prior to the hurricanes, the Louisiana Department of Health and Hospitals (DHH) commissioned a programmatic systems and services review of mental health care in Louisiana, resulting in a document that was published in June, 2006, and did include evaluation of the system post-hurricanes. The final document, *A Roadmap for Change: Bringing the Hope of Recovery to Louisianians with Mental Health Conditions* was the result of this review, and included recommendations for transformation. A synopsis of the major findings highlighted fifteen focus areas. While the study is a thorough critique of the system, it is also aspirational. The administration is utilizing the findings of the report in studying and setting priorities, and evaluating recommendations made therein. The *Roadmap* report, along with the recommendations for improvement, was presented and discussed in public forums across the State during the fall of 2006. A summary of the *Roadmap* findings is found in the Table in this section.

It has been previously acknowledged that in order for meaningful progress to occur, reform must take a broad coordinated approach involving federal, state, and local governments, public/ private partnerships and citizens coming together. The recognition by the public that mental illness is a real and treatable health disorder continues to be a challenge.

As stated in the final *President's New Freedom Commission Report*, successful transformation of the mental health service delivery system to promote recovery rests on two key principles:

1) Services & treatments must be consumer- and family- driven; geared to give consumers real and meaningful choices about treatment options and providers, and not oriented to the requirements of bureaucracies.

2) Care must focus on increasing individuals' ability to cope successfully with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

SYNOPSIS OF MAJOR FINDINGS BASED ON *ROADMAP* SYSTEMS AND SERVICES REVIEW*

	FOCUS AREA	FINDING
1.	Vision & Mission	Louisiana has no widely understood or accepted and shared vision to guide the delivery of mental health services to adults, children, and families.
2.	Leadership	Key leadership positions in DHH have experienced turnovers, and some are filled by persons in "acting" roles.
3	Service Delivery Structures; State (DHH) / District Governing Relationship	While progress has been made to provide health care services under a District/ Authority model, much of the State's structures providing public mental health, substance abuse and developmental disability services currently operate under a variety of differing geographic and process models.
4	Organization and Role of Office of Mental Health	Louisiana's increasing move toward a district model for delivering services in the community will necessitate the role and function of the OMH to change from that of principally a service provider to one where the office is the coordinator of a more distributive and integrative model of service delivery.
5	Financing & Budget	Louisiana has an inadequate financing strategy to ensure access to appropriate mental health services. Louisiana lacks a comprehensive framework to use for understanding and assessing the adequacy of its financial investment in mental health services. Louisiana has not taken sufficient steps to secure existing financial resources nor to fully seize opportunities to increase resources for mental health services.
6	Evidence-based Practices	Louisiana currently makes very limited use of evidence-based and best practices and in only isolated areas of the State, never seeming to be brought to a statewide scale. Where these practices do exist, soon after Federal or other grant dollars that helped to initiate them end, they can no longer be afforded or otherwise supported, and are abandoned.
7	Acute Care/ Crisis Response Network	Louisiana lacks alternatives to traditional crisis services thus creating an even greater shortage of the State's acute, inpatient bed capacity.
8	Suicide Prevention and Response	Louisiana ranks 38th in the nation in terms of suicide rates. There is much uncertainty and concern across the State as to whether the suicide rate has increased in the aftermath of the hurricanes. The data needed to draw these conclusions is incomplete.
9	Cultural Competence and Eliminating Disparities	The capacity of Louisiana's State Departments, agencies and providers are challenged in meeting the mental health care needs of the State's highly diverse, heterogeneous populations.
10	Workforce Development	As is the situation in every state, Louisiana is facing a serious shortage of professionals an para-professionals trained in providing evidence-based and best practice mental health services for children, adults, and older adults.
11	Children, Youth, and Families	In Louisiana, only 7-14% of children with mental health disorders are receiving services and only 13% of the Office of Mental Health's budget is spent on children's services.
12	Primary Care Integration	The primary healthcare needs of Louisiana communities are well understood, however, DHH lacks a process to assess behavioral health needs at the community level, thus missing opportunities for significant integration and collaboration.
13	Homelessness and Housing	Serious mental illness and substance abuse are the two most significant factors contributing to homelessness in Louisiana. The State faces a serious lack of affordable housing, especially for people with disabilities, a situation exacerbated by the impact of Hurricanes Katrina and Rita.
14	Employment	Adults and youth with mental disorders are drastically unemployed and underemployed in Louisiana. Effective policy and service strategies have recently been clearly identified and, if implemented, could significantly improve rates of employment for mental health consumers.
15	Criminal Justice	Mental health services for those individuals and families who come before the State's criminal, family, and juvenile court system are woefully inadequate.

*taken from *A Roadmap for change: Bringing the Hope of Recovery to Louisianans with Mental Health Conditions: Recommendations for Transformation Based on Findings from a Review of Mental Health Systems and Services. Prepared for: Louisiana Department of Health and Hospitals. Prepared by: Behavioral Health Policy Collaborative, Alexandria, VA; Technical Assistance Collaborative, Boston, MA. June, 2006.*

Louisiana's Plan for Access to Mental Health Care

The *President's New Freedom Commission Report* found that the mental health care system needs to be fundamentally transformed to become recovery oriented, to integrate programs that are fragmented across levels of government and different agencies, and to replace unnecessary institutional care with efficient, effective community services. In response to these concerns, previous Governor Kathleen Blanco issued an Executive Order (KBB 05-16) calling for development of *"Louisiana's Plan for Access to Mental Health Care."* To begin to address the deficiencies noted by the *New Freedom Commission Report* and carry out the Executive Order, a series of stakeholder meetings were held throughout the state to gain knowledge, input, and recommendations on how we can all work together to improve access to mental health care. Workgroups were then established with representation from thirteen State level Departments and various other stakeholders, including advocacy groups. The thirteen agencies mandated by the Executive Order are listed below.

- Department of Health and Hospitals (lead agency)
- Department of Public Safety & Corrections
- Department of Social Services
- Department of Transportation & Development
- Department of Education
- Department of Labor
- Department of Insurance
- Office of Youth Services
- Department of Veteran's Affairs
- Louisiana Housing Finance Agency
- Governor's Office of Elderly Affairs
- Governor's Office of Disability Affairs
- Louisiana State University Health Sciences Center

The charge of this group was to develop a comprehensive and effective plan for the transformation of Louisiana's mental health care system, including recommended administrative and legislative actions that may be reasonably achieved by 2010 with resources available to the state. The work of this group is ongoing, and six Goals have been identified, each having Strategies, Objectives, and Measures, along with timelines for completion of each. The workgroups are establishing Implementation plans for each identified strategy. Discussions of the task force have included the importance of sustainability of this plan through the state administration change now that Louisiana has a new Governor and many new legislators. The importance of widespread community and advocacy support for the plan has been emphasized as the key to sustainability, and the group is in restructuring mode at present. The Goals of Louisiana's Mental Health Plan are listed in the following Table:

LOUISIANA'S PLAN FOR ACCESS TO MENTAL HEALTH CARE	
Goal One:	Increase the use of evidence based, developmentally appropriate practices, for children, adults, and families to access needed mental health services.
Goal Two:	Establish an accessible continuum of crisis services and crisis avoidance and provide a realistic array of treatment services in both the private and public sector.
Goal Three:	Provide effective services for children, young adults and their families which are designed to meet their emotional, cognitive, developmental and physical needs, provided in environments to ensure success.
Goal Four:	Provide primary health care and behavioral health care at comprehensive access sites.
Goal Five:	Provide all individuals with behavioral health (mental health and/or addictive disorders) conditions with appropriate individualized supportive services to secure and maintain their education, employment and housing goals.
Goal Six:	Define, establish, and sustain the Leadership role of the Office of Mental Health in order to efficiently and effectively accomplish "Bringing the Hope of Recovery to Louisianians with Mental Health conditions" as delineated in the *"Roadmap for Change."*

Cornerstone Project

Prior to the storms of 2005, the Office of Mental Health was aggressively pursuing accreditation for the OMH outpatient clinics. However, during the process it was recognized that the necessary infrastructure to support a quality organization was lacking; and certainly, this lack of infrastructure only intensified problems with the recovery from the storms. Thus, the decision was made to postpone temporarily the goal of accreditation in order to develop and implement the infrastructure to support the organization. "The Cornerstone Project" resulted from this sequence of events. The Cornerstone leadership team consists of state office staff, a national consultant and the regional manager and medical director from each region. Meetings are held on a monthly basis with subgroups meeting in between those larger meetings. Information on the four 'Cornerstones' and the status of the development of each project are listed below.

Recovery and Resiliency Cornerstone: The Office of Mental Health has made the decision to base the system of care on a recovery and resiliency philosophy. The goal of this cornerstone is the monumental job of not only training, but transforming the hearts and minds of the entire work force to embrace this new model of care. Thus far, the OMH leadership team has heard a presentation from Dr. Dan Fisher, a nationally known recovery leader and also has had an on site visit to "The Village" a national center of excellence in the Recovery model. In June, 2007, OMH sponsored a broader training on recovery principles for about 150 clinical and administrative leaders within the OMH organization. The next step of transformation is to get an assessment of our system completed with a national consultant who will evaluate each system and educate staff. Each region has begun to develop plans and implementation strategies specific to their own regions and clinics so that the model is shaped in ways that are meaningful to each region. Another part of this project has resulted

in an attempt to initiate peer support services from both the programmatic perspective and through efforts to obtain Medicaid funding for these services.

Utilization Management Cornerstone: Again with the help of a consultant, OMH is developing a utilization management (UM) system for the OMH clinics. Standardized target population definitions, service definitions, client profiles, intensity of need criteria, priority determination, and service packages are part of the UM system. Additional UM elements being implemented include centralized scheduling and productivity standards for staff. Use of the LOCUS level of care instrument establishes criteria for the target population, intensity of need, and priority levels. OMH has purchased the electronic version of the LOCUS complete with training on the use of the LOCUS instrument. Training on the LOCUS state-wide began in July, 2008 and will be completed in the fall. The target date for implementation of the use of the LOCUS is October 2008. A UM Readiness Survey will be completed by end of July 2008 and UM implementation plans will be completed by end of September 2008.

Credentialing and Privileging Cornerstone: In addition to the traditional credentialing model from the hospitals, a credentialing plan has been completed for the clinic medical staff, and a credentialing plan to include a competency assessment program for other licensed treatment staff is in progress. The completion of this cornerstone will result in a credentialing plan for all licensed independent practitioners. Manuals will be developed containing all of the accompanying policies for credentialing licensed staff within the Office of Mental Health (OMH). A contractor has been hired to complete the policies and do the initial credentialing of OMH employees. A consultant is working to further develop policies in conjunction with the development of competencies relative to OMH Core Services. Centralized credentialing will be maintained with regional staff involvement. Competency assessments along with a remediation plan for poorly performing employees will be maintained on the regional level as part of the overall credentialing process.

Performance Improvement Cornerstone: This cornerstone will result in the development of a comprehensive performance improvement plan so that data driven decisions will be the norm. Work in this cornerstone has not yet begun.

The President's New Freedom Commission on Mental Health - Achieving the Promise: Transforming Mental Health Care in America, and the OMH Policy for Block Grant Proposals and Allocations

The *President's New Freedom Commission* Goals were utilized in the development of an Office of Mental Health Policy (Policy # 0032006) entitled 'Block Grant Proposals and Allocations' that was signed and implemented in January of 2006. The Policy was developed conjointly with OMH staff and the Planning Council. The purpose of the policy is to ensure that an inclusive system for the effective and efficient allocation, expenditure, monitoring, and accounting of Block Grant funds is in place. The procedures outlined in the policy are designed to promote accountability to the Center for Mental Health Services (CMHS), the Mental Health Planning Council, and the Office of Mental Health executive management. Of significance in priority setting, the policy directs that all proposed expenditures in each Intended Use Plan be listed according to established categories. These categories have been cross-walked with the six Goals of the *New Freedom Commission* to promote awareness of the needs in each category, as well as to emphasize these categories as priorities. The Crosswalk Tables are below, separated into Adult and Child/ Youth categories. The reader is also referred to the Appendix to see the actual monetary allocations in each of the Intended Use Service Types; as well as to Adult Section, Criterion 5, Table C.

PRESIDENT'S NEW FREEDOM COMMISSION & LOUISIANA OMH INTENDED USE CATEGORIES - ADULT SERVICES CROSSWALK -

NEW FREEDOM COMMISSION		LOUISIANA OMH POLICY	
Goal #	**Goal**	**Adult Service Category**	**Intended Use Service Types**
2	Mental Health Care is Consumer & Family Driven	Adult Employment	Employment Programs; Employment Development & Services
2	Mental Health Care is Consumer & Family Driven	Advisory Council Support	Regional Advisory Council (RAC) Support
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Assertive Community Treatment	Assertive Community Treatment (ACT) and ACT-like Outreach Services
1 **2**	Americans Understand that Mental Health is Essential to Overall Health Mental Health Care is Consumer & family driven	Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support; Supported Adult Education
2	Mental Health Care is Consumer & family driven	Consumer Liaisons	Consumer Liaisons
2 **5** **6**	Mental Health Care is Consumer & family driven Excellent Mental Health Care is Delivered & Research is Accelerated Technology is Used to Access Mental Health Care & Information	Consumer Monitoring and Evaluation	Management Information System; Consumer-Directed Service System Monitoring; Consumer Liaisons
2 **4**	Mental Health Care is Consumer & family driven Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Consumer Support Services	Consumer Initiated Programs; Community Care Resources; Community Resource Centers; Case Management; Consumer Support; Medicaid Enrollment; Consumer-Education, Support and Empowerment
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Crisis Response Services	Crisis Line; Crisis Stabilization; Crisis 24 hour screening & assessment; Mobile crisis response

NEW FREEDOM COMMISSION		LOUISIANA OMH POLICY	
Goal #	**Goal**	**Adult Service Category**	**Intended Use Service Types**
1 **3** **4**	Americans Understand that Mental Health is Essential to Overall Health Disparities in Mental Health Services are Eliminated Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Mental Health Treatment Services	Psycho-social Day Treatment; Forensic Program; Co-occurring Disorders Treatment
2 **6**	Mental Health Care is Consumer & family driven Technology is Used to Access Mental Health Care & Information	Planning Operations and System Development	Planning Operations: Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff; Office Operations; Member Travel & Training; Regional Advisory Council Training; Management Information Services
2	Mental Health Care is Consumer & family driven	Residential / Housing	Housing Development and Services; Housing; Foster Care; Group Homes; Supervised Apartments; 24-Hour Residential Housing Support Services
1	Americans Understand that Mental Health is Essential to Overall Health	Respite	Respite Services and Supports
5	Excellent Mental Health Care is Delivered & Research is Accelerated	Staff Development	OMH Workforce Recruitment, Development and Retention; Staffing for Bureau of Workforce Development
2 **3**	Mental Health Care is Consumer & family driven Disparities in Mental Health Services are Eliminated	Transportation	Community / Rural Transportation
3 **4** **6**	Disparities in Mental Health Services are Eliminated Early Mental Health Screening, Assessment, & Referral to Services are Common Practice Technology is Used to Access Mental Health Care & Information	Other Contracted Services	Comprehensive Mental Health Services; Management Information System; Infrastructure Development; PODS (Public Outreach Depression Screening); Forensic Services

PRESIDENT'S NEW FREEDOM COMMISSION & LOUISIANA OMH INTENDED USE CATEGORIES - CHILD/ YOUTH/ FAMILY SERVICES CROSSWALK -

NEW FREEDOM COMMISSION		LOUISIANA OMH POLICY	
Goal #	**Goal**	**C/Y Service Category**	**Intended Use Service Types**
2	Mental Health Care is Consumer & Family driven	Advisory Council Support	Regional Advisory Council (RAC) Support
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Assertive Community Treatment	Assertive Community Treatment (ACT) and ACT-like Outreach Services
1 **2**	Americans Understand that Mental Health is Essential to Overall Health Mental Health Care is Consumer & Family driven	Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support
2	Mental Health Care is Consumer & Family driven	Consumer Liaisons	Consumer Liaisons
2 **5** **6**	Mental Health Care is Consumer & family driven Excellent Mental Health Care is Delivered & Research is Accelerated Technology is Used to Access Mental Health Care & Information	Consumer Monitoring and Evaluation	Management Information System; Consumer-Directed Service System Monitoring; Consumer Liaisons
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Crisis Response Services	Crisis Line; Crisis Stabilization; Crisis 24 Hour Screening & Assessment; Mobile Crisis Response
2 **4**	Mental Health Care is Consumer & family driven Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	Family Support Services	Family Support Services; Wraparound; Medicaid Enrollment; Family Support Liaison and Program; Parent Liaisons; Family Training; Parent / Family Mentoring; Nurse Visitation Program; Community Care Resources; Rural Mobile Outreach Programs; Therapeutic Camp

NEW FREEDOM COMMISSION		LOUISIANA OMH POLICY	
Goal #	**Goal**	**C/Y Service Category**	**Intended Use Service Types**
2 **6**	Mental Health Care is Consumer & Family driven Technology is Used to Access Mental Health Care & Information	Planning Operations and Systems Development	Planning Operations: Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff; Office Operations; Member Travel & Training; Regional Advisory Council Training; Management Information Services
2	Mental Health Care is Consumer & Family driven	Residential / Housing	Housing Development and Services; Housing; Foster Care; Group Homes; Supervised Apartments; 24-Hour Residential Housing Support Services
1	Americans Understand that Mental Health is Essential to Overall Health	Respite	Respite Programs
4	Early Mental Health Screening, Assessment, & Referral to Services are Common Practice	School-Based Mental Health Services	School-Based Clinics; School-Based Services; School Violence Prevention
5	Excellent Mental Health Care is Delivered & Research is Accelerated	Staff Development	OMH Workforce Recruitment, Development and Retention; Staffing for Bureau of Workforce Development
2 **3**	Mental Health Care is Consumer & Family driven Disparities in Mental Health Services are Eliminated	Transportation	Community / Rural Transportation
3 **4** **6**	Disparities in Mental Health Services are Eliminated Early Mental Health Screening, Assessment, & Referral to Services are Common Practice Technology is Used to Access Mental Health Care & Information	Other Contracted Services	Comprehensive Mental Health Services; Nurse Home Visitation Program; Management Information Services; Infrastructure Development; PODS (Public Outreach Depression Screening)

Criterion 1: Comprehensive Community-based Mental Health Services

Many of the activities that are administered or supported by OMH were disrupted as a result of Hurricanes Katrina and Rita, storms that battered the state in August and September of 2005. Many programs and services have been reorganized and were resumed as soon as feasible; however, it is recognized that some impact on current and future services has been and will be unavoidable. The opportunity to re-build a *better* mental health system is recognized by all.

The effort to provide an improved and seamless system of services is an ongoing goal. Service and system integration at the local level as well as the organizational level continues. The integration of the acute psychiatric inpatient hospital units with the various community based programs continues, utilizing the Louisiana State University (LSU) Medical Center administration's help and commitment. OMH and the LSU hospitals have implemented statewide and local agreements that govern the roles and responsibilities of the two organizations in their collective efforts at developing a more comprehensive range of acute care services for adults. This agreement addresses budgetary, clinical, and human resource issues.

Mental health services for individuals and families who come before the State's criminal, family, and juvenile court systems are inadequate. In the regular session of 2008, the Legislature extended the study of the feasibility of implementing the components of an effective comprehensive statewide system to address the demands of the increasing adult forensic population and its economic burden on health care service in the state. Legislation addressed the time frame for forensic evaluation of adults, evaluation of the mental capacity to proceed to trial in criminal cases; and deals with the burden of proof regarding mental capacity determinations.

In the 2008 regular session of the Louisiana legislature, the Department of Health and Hospitals is asked to study the development and implementation of civil commitment procedures for the treatment of sexually violent predators and child sexual predators. The Sexually Violent Offender Subcommittee is requested in its report to outline how the proposed scheme will accomplish the goals of civil commitment for sexually violent predators, with a focus on best clinical practices delivered in an efficient, safe environment in a comprehensive and fiscally responsible manner. The committee is also asked to address the impact on the civil mental health population, and how to best maintain public safety.

The partnership created between OMH/ Metropolitan Human Services Authority and the Orleans Parish Court to fully identify and understand the mental health service delivery needs of those individuals participating in drug court with co-occurring disorders continues. The goal of the collaboration is to develop a more efficient, seamless system of care for those drug court participants requiring mental health services.

The Office of Mental Health has received a Jail Diversion Grant from SAMHSA. This program is designed to result in successful community reintegration and sustained recovery of enrolled clients. The project will also focus on crisis intervention training for city and parish law enforcement,

establishment of peer support specialists/ liaisons post-program graduation, implementation of a 'Double Trouble in Recovery' program for participants with co-occurring disorders, increased access to psychiatrists through utilization of telemedicine, and education of the community at large through a regional conference. Partial funding from the state (non-grant funding) has been committed for two project positions. There also is a stakeholder group that includes judges who are helping to direct this initiative.

Further development of a continuum of services for integrated care of adult consumers who have been judicially committed and served through the forensic system continues. OMH strives to expand community-based forensic services in New Orleans and Baton Rouge. A number of Forensic Mental Health Consumers have moved into community living environments. Many are now eligible and receiving Medicaid benefits, including Mental Health Rehabilitation Services and SSI payments that provide for their community residence.

The Supervised Transitional Residence and Aftercare Program (STRAP) offered through Harmony Center, Inc., provides a 24 hour, 7 day per week supervised transitional setting for consumers who are on court ordered conditional release status. Forensic consumers who reside in the State of Louisiana are eligible to participate in this service if they are legally adjudicated Not Guilty by Reason of Insanity (NGRI) or Unrestorably Incompetent to Proceed ("Lockhart"). The individualized program is designed to assist SMI consumers to develop daily living skills, prepare for vocational adjustment, and to reenter the community. Consumers in this program have obtained employment in competitive workplace settings and moved to greater levels of independent living.

Increasing numbers of civil psychiatric beds are being used for forensically-involved persons, thereby limiting access to inpatient psychiatric care for the general population. More than a majority of the existing civil inpatient service capacity is constricted by the demand for forensic inpatient services. One approach to reducing this trend is to establish and support more community based forensic programs and diversion programs for forensic consumers

The Office of Mental Health has a formulary that includes all of the newer antipsychotic agents, antidepressants, and mood stabilizers. Thanks to the efforts of outpatient clinic employees, the Office of Mental Health has capitalized on the available Patient Assistance Programs to offset the cost of providing medications to OMH outpatient clinic clients. Staff members have also assisted all clients who are eligible with obtaining Medicare Part D and Medicaid Access. As a result of the work this past year, the Office of Mental Health expects to save approximately $5 million in the just-ended fiscal year from its six Regions alone.

It is estimated that OMH pharmacies will dispense medications valued at over $9 million from Patient Assistance Programs and sample medications in 2007 and that local community pharmacies will dispense medications valued at roughly an estimated $20 million utilizing Medicaid and Medicare funding to OMH clients.

The OMH Pharmacy and Therapeutics Committee has promulgated several new policies that improve quality and accountability in areas of procurement, storage, prescribing, and dispensing of prescription medications, and the committee continues to facilitate improvement and enhancement of data quality and availability. Region VII is piloting the Texas Medication Algorithm Project. ELMHS Pharmacy and the all the regional pharmacies completed a pilot of a program that audits all invoices to ensure compliance with contract pricing from wholesalers.

There are currently efforts by the OMH Medical director and Pharmacy director to develop clinical pharmacologic treatment protocols for all the major mental illnesses that are currently treated in OMH clinics. These protocols will be finalized after review by the OMH Medical Directors and OMH Pharmacy and therapeutics committee. The formulary will then be adjusted to reflect those medications necessary to implement those protocols. It is anticipated that all of these protocols will be in place within the next fiscal year.

OMH now has a policy that allows non-physician professionals who have prescriptive privileges to prescribe within OMH facilities. The inclusion of Medical Psychologists and Advance Practice Nurse Practitioners allows patients and consumers greater access to the care they need. Several mental health centers have taken advantage of this added resource to the benefit of their consumers.

The Mental Health Rehabilitation program provides services in the community to adults, children and youth with SMI/ EBD. The available services include Assessment, Reassessment, Community Support, Group Psychosocial Skills Training, Counseling, and Medication Management. Optional services for children/ youth are Parent Family Intervention-Intensive, which provides intensive home-based services to assist children who are at-risk of being placed out of their homes. All authorized providers in the network have been accredited by JCAHO, CARF, or COA as of March 31, 2006. Ongoing training by the MHR Provider Training unit continues, providing updated information on conducting assessments, performing LOCUS and CALOCUS screenings, and other technical issues. Regular face to face meetings with members of the provider network are held statewide each quarter. Physician/Psychiatrist review has been added to the functions within the Prior Authorization Unit, and an extensive and thorough redesign and enhancement to the administrative structure and operations of all aspects of the program is fully underway with the assistance of the National Council of Community Behavioral Healthcare. The moratorium, which had limited any new providers from enrolling as MHR providers was lifted as of August 1st, 2007, so as to meet growing recipient access demands.

Cultural and diversity needs in the service delivery system are under-developed, as are the special needs of the transitional age and older adult population. Service providers with specialties in these areas are under-represented, and there is need for more staff training. These areas are receiving more emphasis. OMH developed a statewide Cultural and Linguistic Competence Planning Committee in April, 2005. It is composed of mental health professionals from each mental health region and LGE in the state. Committee members are mental health professionals, persons with mental illness, family members and mental health advocates. Video-conferences are utilized to allow everyone access to monthly meetings. The Cultural and Linguistic Competence Committee involves persons with mental illness and family members fully in its work, including sharing in decision-making, as emphasized in Goal #2 of the *President's New Freedom Commission Report*. The committee began research on the number of persons with mental illness being served around the state (by race, ethnicity, gender and age), the numbers in the state based on federal estimates, and the number being served in the non-profit sector statewide. After this data gathering phase, the committee reviewed data regarding staff demographics, clinic locations, accessibility, etc. to begin to determine cultural and linguistic competence issues and disparity issues in OMH, addressing Goal # 3 of the *New Freedom Commission Report*. Hurricanes Katrina and Rita interrupted the data gathering, and due to the relocation of much of the Louisiana population, this process will have to be redone when the population shifts slow down and the infrastructure in the public and non-profit sector is completely re-established. After the storms, priorities in OMH work responsibilities for the Cultural Competence

Officer became on-going work with Louisiana Spirit, the federally funded FEMA/SAMHSA grant program awarded to Louisiana. During the development and implementation of the statewide Louisiana Spirit Program, the committee did not meet between September and December, but has begun meetings once again. The committee developed and recommended a Cultural Competence Plan for Louisiana Spirit. Initial cultural and linguistic competence training sessions for the Louisiana Spirit staff occurred in August, 2006. Trainings were again held in May, July, and November, 2007. Training is scheduled in August, 2008 to provide new employees with this knowledge. Additional conversations around cultural competence have continued to allow employees to discuss issues they are experiencing as they provide outreach and crisis counseling to hurricane survivors and other community members throughout the state. The *President's New Freedom Commission Report* was used along with several other national publications in developing the Cultural and Linguistic Competence Plan. Since the Committee's inception, it has researched fragmentation and gaps in care, mental health disparities and the effects of trauma from the hurricanes on persons with mental illness and the communities that received these individuals after they were displaced. The Cultural Competence Plan is being used to guide, monitor and evaluate cultural and linguistic competence, so that citizens can receive appropriate services to reorganize and rebuild their lives.

OMH continues to explore is ability and capacity to expand the provision of evidence-based practices (EBPs). The State has isolated pockets where evidence-based practices are in place, but the practices have not been brought to a state-wide scale. Further complicating the situation is the fact that funding for continuing the EBPs is limited, and as a result, sometimes the programs are disbanded.

The Child/Adolescent Response Team (CART) response process is a time-limited series of crisis intervention steps. The six phases of the "CART" approach to crisis intervention consists of a cluster of services available to children and families that is initiated through a crisis line. The crisis plan establishes a time-line addressing all necessary elements (i.e., least restrictive setting issues, family supports, transportation, etc.) and includes a plan to link the family back to any pre-existing resources or new resources as needed. There are now crisis services for children statewide, although two LGEs (JPHSA and FPHSA) utilize a variation of CART.

The Louisiana Department of Health and Hospitals and the American College of Obstetricians and Gynecologists – Louisiana Section has a relatively new program designed to address poor birth outcomes in Louisiana. The Screening, Brief Intervention, Referral, and Treatment (SBIRT) program hopes to reduce the use of alcohol, tobacco and illicit drug use during pregnancy. The program also screens and provides appropriate referral for domestic violence and depression in pregnancy.

Although the separation of treatments for mental illness and substance abuse is still all too common in the State, several initiatives, primarily funded through competitive grants, are underway to address this unnatural division of services. With the awarding of the Co-Occurring State Infrastructure (COSIG) Grant, OMH and the Office of Addictive Disorders are working together to transform a system that has not heretofore had the capacity to treat both substance abuse and mental illness in a seamless way. The original focus of COSIG was on adults, but there is some inclusion of the child/youth population, since the state did not receive the CASIG Grant. The infrastructure changes that are currently occurring within COSIG will have a direct effect on all persons receiving mental health and addictive disorder services.

The expansion of and training for newer programs such as the integrated treatment for co-occurring disorders, although being utilized in many regions/ LGEs prior to the hurricanes, was originally reduced to a degree secondary to the redirection of limited fiscal and human resources following the hurricanes in 2005. However, in some areas, the development of integrated programs has been hastened because integration is a natural way of reducing cost and conserving resources. The hurricanes have, however, generally delayed statewide implementation of formally defined programs that hold to the standards set by the fidelity measure.

Adequate, safe, and affordable housing, already a problem in the state, became a major obstacle due to the widespread devastation and destruction of housing both in rural areas, and in highly populated areas hit by the hurricanes. Safe, stable housing has become a pressing issue, as the recovery and rebuilding efforts meet with barriers. Serious mental illness and substance abuse continue to be the two most significant factors contributing to homelessness in the State. There is a lack of affordable housing, especially for people with disabilities, and this situation has been exacerbated by the impact of the hurricanes. The need for rental subsidies to assist people with disabilities who are homeless due to the skyrocketing housing costs of in the post-disaster housing crisis is evident. Estimates of the number of persons with mental illness, inclusive of those with co-occurring addictive disorders, who are homeless is approximately 13,184 persons, or 30% of the total homeless population as reported in the 2006-07 annual shelter survey. Aside from the dire need to create a new stock of affordable housing to replace that lost in the hurricanes, there is a considerable need for community based support services to assist people with mental illness in attaining and retaining their housing. At a minimum, an increase in available outreach programs, such as those provided through the Projects to Assist in the Transition from Homelessness (PATH), that include assessments, stabilization and preliminary treatment services, transportation, and advocacy is needed. Easy availability to resource centers for use as address and telephone communication sites are also needed. Funding through the PATH program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. The availability of a statewide system of Strengths Based Case Management would be a significant improvement in the quality of community based supports available to persons with mental illness.

A lack of appropriate education directly impacts the ability of adults and youth with mental health disorders to find employment, and these individuals are oftentimes unemployed and underemployed in Louisiana. OMH remains invested in providing school-based mental health and health-related services in academic settings. OMH has a Memorandum of Understanding with the Special School District #1 of the Department of Education to provide educational services to children and youth hospitalized in an OMH facility. Families Helping Families, under contract to OMH, assists parents in preparation for and participation in the Individual Education Plan (IEP) process.

Following Hurricanes Katrina and Rita in 2005, the school system was virtually destroyed in several parishes. Approximately 500 schools were damaged and 80 were destroyed. The Department of Education has re-opened schools in stages as facilities were repaired and faculty and staff became available in the New Orleans area. Schools in the New Orleans area have benefited from mental health and stress management support for faculty, staff and students. Louisiana Spirit, through the Office of Mental Health, has been a participant in the mental health recovery of educational staff, students, and their families.

Better coordination of mental health, medical, housing, recreational and employment services for consumers with mental illness is necessary to fit the needs and individual aspirations of persons with

severe mental illness. Interagency agreements, proactive use of legislation, the utilization of outside funding to build full service, regional resources for mental health consumers, with the ability to provide, coordinate, and adjust services needed by that population will improve the care that citizens with mental illness will receive.

An increase in the number of suicides and suicide attempts among victims of the hurricanes has been noted, increasing the importance of addressing this problem. The Louisiana Partnership for Youth Suicide Prevention, funded by a SAMHSA grant is designed to address this leading cause of death among Louisiana's youth and young adults. The initiative advances strategies of the Louisiana's Youth Suicide Prevention Plan, and aims to strengthen public and private partnerships, cultivate community efforts, mobilize existing resources, expand gatekeeper training, and increased awareness of youth suicide and suicide prevention efforts. The project targets 10,000 youth and young adults ages 10 to 24 years who are middle, high, and college students and were directly affected by Hurricanes Katrina and Rita. The grant provides $300,000 annually over a three-year period to provide services in the hurricane-impacted parishes of Calcasieu, Cameron, Jefferson, Orleans, Plaquemines, St. Bernard, Vermillion, and also to evacuees who live in East Baton Rouge Parish.

The Office of Mental Health continually reviews several sources of data for determining gaps and unmet needs. Numerous quality indicators are obtained from the OMH Quality Management Report that is updated on a quarterly basis. The data in this report was formulated from recommendations from the Mental Health Statistics Improvement Program (MHSIP). Specific data requests can be made via the Data Quest system developed by OMH.

The variety and extent of data collected provides rich and unique opportunities for objectively evaluating and improving the mental health care system in Louisiana. The C'est Bon and LaFete Surveys are the consumer-to-consumer methodology developed by Louisiana for collecting information to measure access, quality and outcome indicators

The percent of consumers discharged from state psychiatric hospitals and re-admitted within 30/180 days of discharge reflects the degree of recidivism. Post-hurricanes, this data could be misleading at first glance. Due to the fact that there are fewer beds because of the closure of some facilities, and the beds are filling as soon as they are emptied, a patient who would previously have been re-admitted based on their mental health status may be forced to wait a longer time for a bed to become available. Thus, the numbers may not necessarily be meaningful or comparable to previous measures. While it was initially anticipated that recidivism would increase, this may not be reflected in the data. As can be understood from this sort of example, the interpretation of all data that is collected post-storms is challenging.

Criterion 2: Mental Health System Data Epidemiology

Review of the number of persons served relative to estimated national prevalence rates is the most common means to determine the extent to which services are covering the need in terms of gross numbers of persons served. Because of the mass evacuations from the State after the hurricanes in August-September of 2005, population numbers are US census estimates. Regardless of the specific numbers, however, services to adults are a critical area of need in the OMH system. Prevalence estimates indicate that only a small proportion of the need is being met by existing OMH services. Of the 83,555 adults with serious mental illness (SMI) in Louisiana, OMH reported a caseload of 27,619 adults in 2008 (as of 6/30/08). SMI is a national designation that includes only those

individuals suffering from the most severe forms of mental illness. The inclusion of individuals who have *any* type of mental illness would increase the population figures, but not the numbers of individuals served, as the OMH facilities are designated to serve only those individuals with SMI as the term is used in Louisiana. Creative and cost-effective ways of reaching increased numbers of Louisiana citizens in need must be found.

Although services directed towards children and adolescents are improving, they remain a critical area of need in the OMH system. Prevalence estimates indicate that only a small proportion of this population is being met by existing OMH services. Of the 97,160 children with serious emotional/ behavioral disorders (SED) or Emotional Behavioral Disorders (EBD) in Louisiana, OMH reported a caseload of 4,286 children and youth in 2008 (as of 6/30/08). SED/ EBD is a national designation that includes only those individuals suffering from the most severe forms of behavioral disorders. As reflected with the adult figures above, those who have any type of behavioral problem would increase the population figures, but not the numbers of individuals served, as our facilities are designated to serve those individuals with SED/ EBD.

Information with which to effectively plan and distribute resources is collected in numerous ways in the OMH. These various methods are briefly described in this section. Database upgrades that will combine information currently found in existing, separate databases into one efficient and comprehensive system is ongoing. The Office of Mental Health Integrated Information System (OMH-IIS) is the end result of the phasing out of older, more cumbersome databases.

There also exist program specific data systems that are supported by OMH. These include the data system for the Child and Adolescent Response Team (CART), Early Childhood Supports and Services (ECSS), the Louisiana Youth Enhancement Services (LA-YES) and the Louisiana Spirit Crisis Program. In each case, these specialized service programs have unique database needs that have been addressed by either building a suitable database in-house or in the case of LA-YES, purchasing a compatible commercial data management system. In each of these cases, efforts have been made to make sure that whatever system is being used, the structure and data formats are compatible with OMH-IIS such that key clinical information can be uploaded to OMH-IIS which is the primary repository of this information for OMH.

The "C'est Bon" adult consumer survey that has resulted in interviews of over one thousand consumers during FY08 has been a rich source of information regarding needs from a consumer and family perspective. Called "La Fete", a comparable survey from parents and families of children with emotional/behavioral disorders was initiated in 2002 and continues. During the spring of 2005, La Fete piloted the use of the Youth Services Survey (YSS) and Youth Services Survey for Families (YSS-F). This MHSIP recommended survey instrument was implemented for the La Fete surveys conducted during the next survey cycle that began in the fall of 2005. Key informant reports by managers, consumers, service providers, and planning council members are also an important source of data. For 2007, the C'est Bon survey was modified to include the full set of questions from the standard MHSIP survey for adults and was implemented in the summer of 2007. The YSS-F was modified to add one question that was missing from the standard YSS-F instrument posted on the MHSIP website. Now, the state will be using the standard MHSIP survey for adults and the standard YSS and YSS-F for youth and families respectively. A further enhancement to the state's consumer survey process will include additional items of social connectedness, functionality, and school attendance which will be included on the C'est Bon Survey starting in July of 2008. A new methodology for collecting the question on legal involvement will be piloted in FY09. Since this

question is phrased differently than our state's current format for the quantitative survey questions, is scored differently, and is more sensitive for consumers, OMH plans to use a version of the TeleSage system. This on-line tool allows multiple methods of data entry including consumer peer assisted survey completion, direct data entry by clerical staff from an answer sheet completed by the consumer, or computer capture of data from a Teleform. If this process is successful, use of this comprehensive data collection process for the entire quantitative portion of both C'est Bon and LaFete surveys may be implemented.

The Office of Mental Health has developed a tool for measuring outcomes of clients receiving services in its mental health centers. The Psychosocial Outcomes Monitoring Scales (POMS) is administered to adult clients by specially trained clinicians at admission, every 6 months during treatment and at discharge or any change to another level of care. This instrument allows the Office to collect data that can be used to determine effectiveness of services delivered as well to report on indicators for the Block Grant, the SAMHSA National Outcomes Measures (NOMS), and for reporting on indicators to the Louisiana legislature. A self-report version of this instrument was developed and briefly field tested. Prior to implementation of this instrument, the OMH embarked on a transformation of its service delivery system based on a Utilization Management (UM) model. Within this context, data that was normally collected at baseline by the POMS, will now be embedded within the new process of screening and assessment under UM. In addition, OMH is planning to pilot a web-based version of an outcome monitoring tool, referred to as TeleSage, which may eliminate the need to embed the POMS items in the screening and assessment process, and which can also be used to capture outcome information on youth. The alternative will be to use the most recently developed self-report version of the youth POMS (Y-POMS) to capture outcome data on the youth population.

In 2004, new, standardized survey forms were developed in order to gather extensive information from the OMH hospitals and the regions/ LGEs. Information gathered is available for inclusion in the annual Block Grant Application, grant proposals, as well as for planning of resources, workforce delivery, etc. The instrument was carefully crafted with the goal of both increasing the validity of the information reported, and also to decrease the amount of time required to complete the survey. This survey form is completed annually and submitted electronically.

The Office of Mental Health continually reviews several sources of data for determining gaps and unmet needs. Numerous quality indicators are obtained from the OMH Quality Management Report that is updated on a quarterly basis. The data in this report was formulated from recommendations from the Mental Health Statistics Improvement Program (MHSIP). Specific data requests can be made via the Data Quest system developed by OMH.

Criterion 3 - Child/ Youth *(Criterion 3 not applicable to Adults)*

Louisiana received a series of FEMA/SAMHSA service grants funded through the Federal Emergency Management Agency and administered through the Substance Abuse and Mental Health Services Administration - Center for Mental Health Services following the natural disasters that impacted Louisiana in 2005. The state is attempting to find means to sustain funding in critical areas of need.

Louisiana Spirit is the project name of Louisiana's hurricane crisis counseling recovery program. Years later, the program continues to provide short-term, community-based crisis intervention,

support, referral services, and other related activities and trainings to individuals and families and providers impacted by Hurricanes Katrina and Rita. The Office of Mental Health has continued to provide administrative oversight and guidance for this program; direct services are provided by contract organizations covering designated parishes.

The various providers have specialized children's teams reaching out into the impacted communities. These outreach crisis counselors provide education and information to parents and caregivers about signs of distress to be aware of in children as well as how to handle them and referrals to appropriate Mental Health resources. On a present-focused, short-term basis, children, youth, parents and caregivers are supported and empowered as they continue to recover from the disasters. The impact of the disasters in 2005 also propelled the further establishment and delivery of additional school-based mental health / health services in the New Orleans and surround areas. There have been various collaborative efforts between the Department of Education, Office of Public Health, and the Office of Mental Health to ensure quality health and mental health service delivery not only in the impacted areas but others as well.

Louisiana continues to have two specialized programs specifically designed for children and their families. These programs are known as ECSS and LaYES. The Early Childhood Supports and Services (ECSS) program is a multi-agency prevention and intervention program that promotes a positive environment for learning, growth, and relationship building for children. ECSS provides infant mental health screening and assessment, counseling, therapy, child abuse and domestic violence prevention, case management, behavior modification, parent support groups, and the use of emergency intervention funds. ECSS also serves to build the infrastructure of the Parishes it serves by training human services professionals, agency personnel, educational and childcare personnel as well as family members and advocates in the specialized area of Infant Mental Health assessment and intervention. ECSS serves children from birth through 5 years of age and their families who have been identified as at risk for developing social, emotional, and/or developmental problems. Risk factors include abuse, neglect, and exposure to violence, parental mental illness, parental substance abuse, poverty, and having developmental disabilities.

ECSS provided Intensive Mental Health training to 21 service providers to provide infant mental health intervention to children 0 through 5 in nine sites providing services in thirteen parishes. ECSS screened 3,153 children between the ages of 0 through 5 for risk factors that may lead to social/ emotional problems later in life. ECSS developed 938 multi-agency service plans for children and their families between the ages of 0 through 5 in the 13 parishes ECSS serves. ECSS referred 717 children to the infant mental health teams for assessment and possible infant mental health intervention.

The Children's Initiative Grant (LaYES Louisiana Youth Enhanced Services Consortium and System of Care) incorporates a comprehensive and coordinated system of care for children with serious emotional disorders. LaYES provides a community-based service system that is family focused and linguistically competent. It has an Administrative Service Organization (ASO) that has oversight of the care management organizations that broker services through a Provider Network. This network's array of mental health, social, and support services utilizes the LaYES consortium and supports its goals of: providing culturally competent social services; involving families in all levels of the delivery system; increasing access of the target population; developing a comprehensive system of care; generalizing evidence-based practices; providing early childhood intervention and prevention of emotional and behavioral problems; facilitating the provision of a broad array of mental health and

other related services, treatments, and supports; and increasing awareness that mental illness affects children, adolescents and youth transitioning to adult systems. The care system confronts the access barriers to improve the needs of children: racial and ethnic disparities, fragmentation of services, an over-reliance on end-stage care, a lack of coverage, and agency-focused rather than child-centered care. LaYES is in partnership with the Department of Health and Hospitals, the Office of Mental Health, a community-based consortium for youth with serious emotional and behavior disorders and their families, public and non-profit child-serving agencies, advocates, and public officials. The consortium came together for the well being of children to address issues of capacity, the desire for quality services and the demand for total systems reform.

HCR 0005 was established in the 2006 regular session to continue the study of issues relating to juvenile competency by creating a task force and to extend the period of time for the study of such issues. The resolution requests the House Committee on Administration of Criminal Justice and the Senate Committee on Judiciary B to meet and function as a joint committee to study and recommend policy directives for the state of Louisiana regarding these and other issues related to juvenile competency. Issues still being researched are the process of competency determination, restoration, and mental health intervention; recommendations for a plan of statewide implementation; and determination of the cost of implementation. It requests input from the Assistant Secretary of the Office of Mental Health. The Louisiana State Law Institute's Subcommittee on the Children's Code continues to meet and develop reforms.

HB 503 was established in the 2006 regular session and was designed to be a broad sweeping legislation enacted as a result of the work of the above-mentioned task force and the Louisiana State Law Institute Subcommittee on the Children's Code. The Office of Mental Health with the assistance of the Office of Youth Development and other individuals and agencies as needed is currently developing its own training curriculum for juvenile competency restoration providers who are licensed by their respective state boards and are employed with DHH. The curriculum is being modeled after best practices utilized by leading states in this field of study. The training for private providers in the community will not be established until the curriculum has been finalized. In order to remain certified, a restoration provider must complete additional training every two years. OMH has established and will maintain a website of DHH qualified providers. OMH's full-time Juvenile Competency Restoration Provider continues to provide services primarily located in Jefferson and Orleans Parishes, but travels around the state as needed.

Criterion 4: Targeted Services to Rural and Homeless and Older Adult Populations

Louisiana is a largely rural State, with 88% (56) of the State's total (64) parishes being classified as rural according to the US Bureau of Census definitions. Consumer surveys consistently rate transportation as a major impediment to the receipt of mental health services. Attempts to ameliorate this problem include the provision of transportation through contracts with transportation providers and the establishment of satellite clinics in underserved and rural areas. Prior to the hurricanes, there was an OMH mental health center or satellite clinic in 45 of the 56 rural parishes. While some centers and clinics were closed initially, all but two clinics are either back in service or have made arrangements for clients to be seen. Satellite clinics that operate with non-traditional hours are also available in some areas of the State.

Although OMH has placed many new programs in rural areas, barriers, especially transportation, continue to restrict the access of consumers to these rural mental health programs. Transportation in

the rural areas of the State has long been problematic, not only for OMH consumers, but for the general public living in many of these areas. The lack of transportation resources not only limits access to mental health services, but also limits access to employment and educational opportunities. The resulting increased social isolation of many OMH consumers with SMI who live in these areas is a primary problem and focus of attention for OMH. Efforts to expand the number of both mental health programs and recruiting of transportation providers in rural areas have seen increases in both.

In an attempt to alleviate access problems, OMH has available teleconferencing systems at 51 sites, including 29 Mental Health clinics, two ECSS sites, five Mental Health Hospitals, two at LA Spirit, one at an OMH regional office, and one at OMH Central Office. All hospitals, three clinics, and OMH Central Office have multiple cameras at their sites. Some of these cameras are dedicated to Telemedicine (doctor/client session) while the others are used for Teleconferencing (meetings, education, etc). The other sites use their single cameras for both Telemedicine and Teleconferencing. The Office of Mental Health had purchased 23 new systems to replace existing out of date systems at the clinics, some of which were damaged by the hurricanes. All of these systems were installed by September 2007. In addition to this equipment, OMH purchased an additional 18 camera/monitor systems in FY08 of which 13 are online as of June 25, 2008.

Estimates of the number of persons with mental illness, inclusive of those with co-occurring addictive disorders, who are homeless is approximately 13,184 persons, or 30% of the total homeless population as reported in the 2006-07 annual shelter survey. Aside from the dire need to create a new stock of affordable housing to replace that lost in the hurricanes, there is a considerable need for rental subsidies to address the escalating housing costs in a market where demand is high and supply is low. In addition to the rental subsidies, there is also a great need for community based support services to assist people with mental illness in attaining and retaining their housing. At a minimum, an increase in available outreach programs that include assessments, stabilization and preliminary treatment services, transportation, and advocacy is needed. Easy availability to resource centers for use as address and telephone communication sites are also needed. Funding through the Projects to Assist in Transition from Homelessness (PATH) program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. The availability of a statewide system of Strengths Based Case Management would be a significant improvement in the quality of community based supports available to persons with mental illness. Efforts to increase available and appropriate housing for persons with mental illness through training and recruitment of housing providers, increased access to existing housing stock, and expansion of resources for housing development and support services continues. OMH and mental health advocates have been extremely active in efforts to insure that people with disabilities are included in the post disaster rebuilding efforts. These efforts resulted in the inclusion of a commitment to the development of 3,000 units of permanent supportive housing in the recovery efforts. Permanent supportive housing is a best practice and offers the greatest degree of consumer choice. These qualities are consistent with Goals 2 & 5 of the *New Freedom Commission Report* as well as with the DHH Real Choice Systems Transformation grant goals.

Rural services, transportation, and services for the homeless populations will continue to be priorities for the State. The goal of having available, accessible rural mental health services and services for homeless consumers in each region and Local Governing Entity (LGE) remains a challenge, and has become more so, given strained resources, staffing shortages, etc., as a result of the hurricanes. Local transportation issues have become more pronounced as a result of budget cuts. The number of

displaced consumers as a result of the destruction of housing in the hurricanes and flooding make these issues more pressing than ever.

As part of the *Louisiana Road Home Recovery Plan*, the Louisiana Recovery Authority (LRA) included in its plan the rebuilding of affordable housing in the areas most impacted by Hurricanes Katrina and Rita. This is to be accomplished through a system of housing development funding incentives that encourage the creation of mixed income housing developments. Also included in this plan is the use of Permanent Supportive Housing as a model for housing and supports for people with special needs, such as people with disabilities. It is a model that provides for housing that is fully integrated into the community through allocation of a percentage of housing units for persons in special population categories within each housing development built, and includes support services that are delivered in the individual's (or family's) home. Adults with SMI, families of children with emotional/behavioral disorders, and frail elderly persons are included within the identified special needs population targeted for the 3,000 supportive housing set aside units. The services to be delivered to persons/families in the target population will be those services likely to help them maintain housing stability.

Services to older persons with SMI are a statewide area of need. The Department of Health and Hospitals recognized this need a year ago, and developed the Office of Aging and Adult Services (OAAS). Although this new Office is not limited to serving the mentally ill population, collaboration is anticipated between OMH and OAAS.

The Louisiana Spirit Crisis Program has included the provision of essential mental health services to priority populations, including older adults. These services are funded by a grant from the FEMA Crisis Counseling program administered by SAMHSA. Louisiana Spirit providers have been reaching out to priority populations since September of 2005, immediately after the hurricanes hit the Gulf Coast. Louisiana Spirit Outreach Workers and Crisis Counselors have canvassed throughout the State offering crisis counseling services to those impacted by hurricanes Katrina and Rita. Given that the elderly are considered one of the priority populations in the State, a special emphasis was placed on reaching out to this population. Louisiana Spirit counselors have worked with entities as varied as local Councils on Aging, Senior Living and Assisted Living sites, Senior Centers, Nursing Homes, and Transitional Living Sites where many individuals have lived since being evacuated after the storms.

Specific Regions and LGEs report having some programming that targets older citizens, however, the need is great, and the services are not consistently available across the state.

Criterion 5: Management Systems

Local Governing Entities (LGEs) have expanded to cover four of the State's ten regions, with two more evaluating their readiness to become LGEs. The development of more LGEs has been legislatively mandated. This expansion will necessarily lead to changes in the current OMH state-operated Area / Region system. The challenges of such a system-wide change are many, including allocation of funding in an equitable and cost-effective way for consumers of mental health services, and the provision of a consistent quality standard for services.

Prior to the hurricanes, OMH had initiated efforts to obtain JCAHO accreditation for all of the OMH-operated community mental health centers and to LGEs wishing to accredit their community mental

health centers. Although still a goal, of necessity, the venture was scaled back due to other pressing needs. Instead, the *Cornerstone Model* was initiated, with a focus on four areas that will form the basis for accreditation. Accreditation is expected to increase credibility, focus activity on performance, develop a common language, ensure consistency and uniformity, and provide a foundation and vehicle for system enhancement. It is also intended to introduce best practices in clinical care, human resource management, and business operations. For many of the same reasons, accreditation of Mental Health Rehabilitation Centers is a requirement.

The OMH Workforce Development Bureau has continued to serve in the role of strengthening community-based services by enhancing capacity and utilization of best practices. Consistent with objectives stated in Goal 5 of *The President's New Freedom Commission*, the Bureau has accomplished several trainings each year. The Bureau also works to provide OMH staff with continued education and as a sponsor of an event makes application to our in-house approval agents for Social Workers, Licensed Professional Counselors and Psychologists.

Throughout the summer of 2008, the Bureau again provided 'Individual Differences and Diversity in the Workplace' trainings, continuing the emphasis on cultural competency. These trainings were repeated in the regions, LGEs and hospitals, furthering the training project that was begun by the OMH Cultural Competency Committee before Hurricanes Katrina and Rita in 2005 and continued in 2007.

In January 2008, the bureau assisted with the launching of *Essential Learning*, a Learning Management System, in conjunction with the Office for Addictive Disorders and the Office for Citizens with Developmental Disabilities and with the support of the Department of Health and Hospitals training staff. The system provides online training, provision of continuing education credits and a learning management system to track training for approximately 4,000 active users in the three offices. *Essential Learning* was funded through the Co-Occurring State Incentive Grant (COSIG) as a component of the effort to sustain ongoing training for treatment of persons with co-occurring disorders.

The Workforce Development Bureau coordinated further trainings on the philosophy and concepts required for transforming the system to a Recovery and Resiliency based perspective. Person Centered Planning was held in October of 2007 for mental health leadership staff. A statewide Mental Health: leadership 'Coming Together Conference' was held in December of 2007 in New Orleans for the Office of Mental Health administrative and supervisory staff in the regions, LGEs and inpatient facilities. The conference provided a wide array of sessions focusing on many aspects of Mental Health Transformation, Louisiana's Plan for Access to Mental Health Care, Recovery, Servant Leadership, and Blending Primary Care into Mental Health. Plans are underway for the 2008 conference this year with a focus on Workforce Development. Plans are to have both Conference Institute Tracks and Workshop Tracks.

Technical assistance has been requested and thus far was offered by the National Technical Assistance Center (NTAC) on transformation efforts. A consultant spent several days with staff in the Central Office of the Office of Mental Health providing avenues for discussion and planning regarding our transformation efforts. A major step in this direction took place July 16, 2008 with the Central Office presentation on Accountable Care Service Delivery and Statewide Change Management Models by David Lloyd. As the OMH Central Office continues to evolve, plans are

underway for the expansion of the Workforce Development Bureau exemplifying the continued commitment to workforce development by the Office of Mental Health.

The Office of Mental Health continues to redirect state hospital resources toward specialized treatment programs promoting further integration with community-based services, and providing community-based options for those persons who have been in long-term state psychiatric hospital care. With the merging of hospital and community resources, OMH continues to evaluate the current utilization of personnel and to redirect inpatient staff positions to community-based services. The redirection of inpatient nursing and social work staff into Assertive Community Treatment teams began in FY 2003, and has continued.

A continuing critical gap is in the level of crisis response services for adults, children, youth and their families. It has long been recognized that this basic service component needs to be further augmented to meet the demand. The hurricanes of 2005 drew further attention to this need, and measures have been taken to improve the available services and emergency response. Each community region has maintained the basic elements of a twenty-four hour crisis response system in the form of hotlines, crisis evaluation, and regional acute inpatient units. However, resources are not at a sufficient level to meet the need, and mobile crisis response services are very limited or unavailable. The capacity to respond to bio-terrorism and/or disasters of any type is inadequate, but has improved substantially with the initiation of several training programs that have been offered to OMH employees. OMH has partnered with the Office of Public Health to provide regular trainings to OMH staff statewide on crisis response. The training curriculum is culturally competent and addresses the mental health needs of responders as well as special populations such as the elderly, medically fragile, and children and families. National Incident Management System (NIMS) training has been made a requirement of employment by OMH.

In addition, in 2005, OMH established a registry of appropriately credentialed behavioral health professionals who are able to provide assistance in disaster mental health, stress management, and multiphase response to disaster incidents. This group that includes many DHH employees was initially trained by an internationally known group of disaster behavioral health experts via a 2 ½ day conference held in New Orleans in May of 2005. This conference was co sponsored by the LSUHSC Department of Psychiatry and included private sector as well as public sector participants.

Fortunately, no hurricanes struck Louisiana during the 2006 or 2007 season, allowing time for further enhancement of behavioral health disaster response plans for each hospital and outpatient facility in OMH, as well as in the Office of Addictive Disorders (OAD) facilities. Experiences of past hurricanes and future weather predictions for Louisiana require the immediate availability of talented and effective teams, ready to respond to crises. Hurricanes Katrina and Rita tested the capacity of the system, and OMH has actively used the "lessons learned" from this catastrophic event.

The OMH service delivery system includes a comprehensive array of services organized to meet the needs of adults with serious mental illness, and children/youth with emotional/behavioral disorder and their families in each region of the state. However, each of the components of the comprehensive service system exists at a level that is far below that required to satisfactorily meet the demand in each region. This is due mainly to fiscal and workforce constraints, and is not due to a lack of awareness about needs, nor due to lacking the will to establish a maximally responsive and comprehensive system of care.

Fiscal and workforce constraints have created a situation where there is demand for services beyond what the system is able to supply. For example, insufficient numbers of direct service providers to address basic treatment and support needs of the community service population continues to be problematic. A common complaint expressed in surveys of consumers is not being able to see their therapist or doctor often enough, and having to participate in group treatment rather than more individualized treatment. The lack of treatment resources inhibits the ability of the State to provide as much in the way of outreach programming as would be ideal. The particular workforce needs in the New Orleans area are of critical importance. Last year, the Department of Health and Hospitals announced a $15M grant that provides incentives to draw health care workers, including mental health professionals, back to the New Orleans area. Health care professionals who commit to providing three years of full-time services in the Orleans, Jefferson, Plaquemines or St. Bernard parishes, will be eligible for loan repayments, sign-on bonuses, malpractice premium payments, relocation expenses, health information technology, continuing education expenses, and income guarantees. According to program guidelines, participants must provide services in a federally designated health professional shortage area to all patients regardless of ability to pay. Participants also must accept Medicare and Medicaid patients, have a sliding fee-scale for low income, uninsured patients, and must be U.S. citizens licensed to practice in Louisiana. Additionally, professionals currently practicing in a health professional shortage area in another region of the state will not be eligible. Even with innovative programs such as this, the shortage of healthcare providers continues to be a pressing concern statewide.

Additional steps are being taken to increase access to qualified prescribers in the community mental health system. OMH has developed a policy that now will permit local CMHCs to contract or employ Medical Psychologists (MPs) and Nurse Practitioners (NPs) who can prescribe psychotropic medications. This policy is designed to ease the burden on the limited number of psychiatrists who are available in the state, particularly in the more rural areas that have found it difficult if not impossible to recruit and retain these medical specialists. There are several Regions that have begun to successfully utilize non-physician prescribers.

The per-capita expenditure for services remains below the national average despite exceptional efforts on the part of stakeholders to provide more sufficient funding levels for mental health programs. Efforts to ease the fiscal needs of the system require a continuously adapting and flexible workforce. Although certainly not yet widespread, and in itself an area of need, the implementation of evidence-based practice provides a framework for the future and a direction for the training of healthcare providers.

Early intervention and prevention programs are essential in meeting the mental health and substance abuse needs of the children/youth and their families of this state. Generally speaking, youth in the custody of the child welfare and juvenile justice system receive mental health and substance abuse treatment in restrictive settings. The private sector provides mainly outpatient services and is not generally a rich resource for the population that OMH serves. Although there have been significant strides made in the implementation of a continuum of care for children and youth that is based on best-practices and evidence-based programs, there is no argument that the population of child/youth with EBD is substantially underserved; and the OMH capacity to serve this population is grossly under-funded and inadequate to meet the continually growing mental health and substance abuse needs.

SECTION II – IDENTIFICATION & ANALYSIS OF SERVICE SYSTEM'S STRENGTHS, NEEDS, & PRIORITIES
RECENT SIGNIFICANT ACHIEVEMENTS
LOUISIANA FY 2009 - ADULT & CHILD/ YOUTH PLAN

Louisiana has had many changes in the last fiscal year, including in January, 2008, a new Governor, Bobby Jindal. The legislature also has a large number of new legislators, due to term limits affecting some incumbent's ability to run for re-election. Coming in on a theme of ethics, reform and transparency, the new administration is still in the process of evaluating and initiating change in many areas of healthcare. Governor Jindal appointed a new Secretary of the Department of Health and Hospitals, Mr. Alan Levine; and a new Assistant Secretary (i.e., Commissioner) of the Office of Mental Health, Ms. Jennifer Kopke. As with any major change, there has been a period of adjustment and OMH is in the process of re-evaluation and re-organization, to allow alignment with the goals of the new administration.

Hurricanes Katrina and Rita, the historic hurricanes of 2005, created a new and on-going challenge for the Office of Mental Health. Since the storms, OMH staff members have been called upon to perform in a variety of settings to aid the citizens of the State. The staff of the office is to be commended for their heroic, creative, and unselfish work ethic during the three years since the storms. The work that has been done to ameliorate the damages from the storm may have overshadowed, and in some cases, delayed the day-to-day typical work, but it has not prevented it. While continuing to provide needed mental health services to the states identified 'target population' the system had to find ways to meet the mental health needs of thousands of Louisianians whose lives will be forever changed by these events.

To address the day-to-day challenges that are faced by the Office of Mental Health, the efforts listed below support the continuing goal of reforming the system. It should be noted that these OMH objectives support achievement of both the prior administration's *Louisiana's Plan for Access to Mental Health Care* and the *President's New Freedom Commission Goals*. While there are also many "mental health system reform" activities and initiatives underway statewide, the challenge to the state is to bring these efforts together into a comprehensive mental health plan for Louisiana that provides quality services that are effective and efficient within the resources available to the state. There are many examples of achievements that are discussed in detail in other sections of the Block Grant, but a few are highlighted here, both hurricane-related and otherwise.

Re-Organization of Metropolitan Human Services District

The Metropolitan Human Services District (MHSD) which encompasses much of the devastated areas in and around New Orleans first became a Local Governing Entity (LGE) one month before Hurricane Katrina ravaged the coast. Under ideal circumstances, the steps to become an LGE are difficult, essentially requiring the district to take over all management functions that were previously taken care of by the state OMH. Once Katrina hit the area, the task became nearly impossible. The initial complications were many, including loss of facilities and staff. MHSD has attempted to regroup since the initial crisis, but has had many obstacles. Much of the experienced staff did not return, and many of those who did were victims of the storm themselves, having their own difficulties with housing, displaced family members, etc. The clinics were not operational, and the MHSD Board of Directors did not have a full complement, and could not function due to resignations and a lack of a quorum. In the time since the hurricane, the district has had two Executive Directors, both of whom

have resigned. The Office of Mental Health stood by ready to assist, but was unable to do so legislatively until requested by the Board or the Executive Director. This request did not come. The recent legislative session re-worked some of the laws and regulations relating to operations of the LGEs to allow the State to assist in situations where the local governing entity has extreme difficulties or is unable to function adequately. The result of this intervention has been the development of a transformation team that has provided management and program support to MHSD, and a collaborative working relationship between DHH, MHSD, and the legislature to restructure operations in the district. To date, the transformation team has provided the following:

- Assessment of MHSD operations and staff and community-stakeholder needs
- Recommended a strategic direction and plan
- Identified crucial MHSD functions and assisted MHSD CEO in the recruitment and hiring of qualified senior management staff
- Facilitated the hiring of program and clinical staff
- Assisted in the prioritization of distinct services for persons with addictive disorders as well as those for persons with co-occurring disorders
- Ongoing consultation to MHSD leadership regarding the design and implementation of evidence-based and best practice intervention and treatment models.
- Assistance to MHSD in building the organizational infrastructure and programs necessary for an effective crisis response system.

Specialized Assistance Targeted to New Orleans

Special legislation was passed in the 2008 Regular session of the Louisiana Legislature that established funding for several initiatives to help citizens from the New Orleans area who were affected by the 2005 hurricanes. Included in this legislation are the following programs and initiatives:

- 24/7 telephone crisis screening and referral system
- Additional support for the already ongoing CIT training
- Additional mental health staff for the New Orleans Parish prison (includes social work, substance abuse, and psychiatry staff) and extends medication availability
- Staff positions (30) to serve storm-affected individuals who do not meet the typical criteria for treatment at the mental health centers
- A crisis receiving center as a pilot project

Louisiana Spirit Hurricane Recovery

The expansion of crisis services and education for trauma survivors has been aided by a grant from the FEMA Crisis Counseling program, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant has allowed the development of a program that is offering essential mental health services at a critical time in the immediate aftermath of the hurricanes in an attempt to prevent the potential onset of more serious, long-term psychological problems and/or substance abuse. During the second year of the program, Louisiana Spirit outreach workers and crisis counselors in the field report observing a correlation between physical infrastructure recovery with mental, emotional recovery. Teaching stress management, coping and self soothing skills that individuals can utilize for themselves in other crisis situations has been an integral focus since the physical recovery process is expected to continue to be slow. Federal funding for the Louisiana Spirit program from FEMA is scheduled to end December 31, 2008, making it one of the longest post-disaster FEMA funded crisis counseling programs in history.

Road Home Housing Program & Housing Initiatives
This program developed by the Louisiana Recovery Authority following the hurricanes will provide access to affordable housing in the Gulf Coast areas where housing was destroyed. While not a direct initiative of OMH, input from the office and consumer groups was received and acted upon. As a result, the Road Home Plan includes a commitment to create 3,000 housing units of Permanent Supportive Housing that will be available to individuals with special needs such as: the frail elderly; those transitioning out of foster care; and those with disabilities, including mental illness; are included in the target population as are households with disabled children. OMH requested and was awarded state funding for housing initiatives that include funds for 600 units of Supportive Housing and 100 units of 24 hour supervised residential care for adults with mental illness and crisis respite care for approximately 700 families with children with SED.

Louisiana Integrated Treatment Services (LITS) & Co-Occurring State Incentive Grant (COSIG)
The Louisiana Integrated Treatment Services (LITS) Model is a DHH initiative to integrate treatment services for individuals with co-occurring disorders of mental illness and substance abuse. Statewide implementation involving both the Office of Mental Health and the Office of Addictive Disorders has been supported by a $3.4 million federal SAMHSA Co-Occurring State Incentive Grant (COSIG). There is an emphasis on increased implementation of integrated treatment services for individuals with co-occurring disorders that is supported by the expansion of LITS and CoSIG. Louisiana was awarded this grant in 2003 and has been steadily developing infrastructure including shaping attitudes and perception and training staff and professionals to implement COSIG activities and interventions reflective of a co-occurring capable system of care. As part of the COSIG initiative and dovetailing with the Cornerstone Project (see below), the Office of Mental Health has developed a standardized screening and assessment system that allows all CMHCs to screen for and detect individuals with co-occurring disorders. A sustainability plan through the HSIC (Human Services Interagency Council) is now in place to sustain the LITS Initiative on state and local levels; and includes workforce development, monitoring capacity and supportive infrastructure.

Cornerstone Model Development
In November, 2006 the Office of Mental Health identified 4 primary components essential to the enhancement and maintenance of Louisiana's public mental health clinic system. These components taken together have been identified as the Cornerstone Model, and are designed to improve performance and accountability in the following fundamental aspects of a system of care. Once these goals are met, the centers should meet national accreditation standards in these four areas.
The four areas of focus are:

1) Recovery and Resiliency;
2) Quality Management;
3) Performance Improvement; and
4) Staff Competencies and Credentialing.

Early Childhood Supports and Services
Early Childhood Supports and Services (ECSS), implemented in the fall of 2002 and currently operating in 13 parishes throughout the state, identifies and mitigates the risks for young children, ages birth through five, who are exposed to risk factors such as abuse, neglect, exposure to violence, parental mental illness, prenatal substance abuse, poverty, and developmental disabilities. The program has two main components to serve families: Infant Mental Health (IMH) and Temporary Assistance to Needy Families (TANF). Both services are provided in accordance with family needs.

IMH assists with the development of the child and the attachment between parent and child. TANF services assist families during emergency times of crisis. Each of the nine sites collaborate with local community representatives and advocates (private and public) that serve as network partners to develop a service plan for families in order to address identified needs.

Louisiana Youth Enhanced Services for Mental Health (LaYES)

In 2003, the OMH formed a collaborative of interested stakeholders and obtained funding from SAMHSA for a System of Care project for children with serious emotional disturbances and their families in the amount of $9.6 million for six (6) years. In 2004, legislation was signed into law creating the LaYES Consortium to develop a comprehensive and coordinated community-based system of care for children with serious emotional and behavioral disorders, targeting youth who are at risk of placement or are placed in the Juvenile Justice System and /or the Child Welfare System. LaYES provided services to 400 children. LaYES is currently operating in Orleans, Jefferson, Plaquemines, St. Bernard and St. Tammany parishes.

Alternatives to Seclusion and Restraint

In 2004, the Office of Mental Health was one of a limited number of states to receive a three-year federal grant for the purpose of developing alternatives to the use of seclusion and restraint in their child and adolescent inpatient psychiatric facilities. Unfortunately, NOAH was officially dropped from the project as a result of Hurricane Katrina devastating the city of New Orleans in 2005. CLSH and SELH remained active participants in the grant process with the gradual inclusion of ELHMS and the re-inclusion of NOAH for training and other opportunities. The state was awarded a "no-cost" extension for the fourth year which will end in September 2008. Nearing the end of the fourth grant year, there has been substantial progress made within the facilities and among the staff with regard to policy and cultural changes. In the spring of 2007 an Ad Hoc Committee was formed to review and revise the Office of Mental Health Position Statement on Seclusion and Restraint. That work was completed in the summer of 2007 and approved by the Assistant Secretary. In the fall of 2007, a committee was formed to review and revise the Office of Mental Health Policy and Procedure on seclusion and restraint. The work was completed in the spring of 2008, submitted to the Assistant Secretary for approval, and formally posted on 07/08/08. The facility-wide data indicated an overall reduction in both seclusion and restraint in all categories - percentage / patients, rate of events, and hours of use; the most notable reduction was in the use of restraint. Overall, 60% of the facility-wide goals were achieved.

Stabilization and Preservation of the Medication Budget and Formulary

The pharmacy continues to offer an unrestricted formulary of medications for mental illness, which includes all of the newer antipsychotics, antidepressants, and mood stabilizers. The ability to offer this variety is due to the emphasis on the use of Patient Assistance Programs (PAP) that have decreased costs for the OMH pharmacies while making maximum usage of free and reduced-cost medications.

Technology is upgraded

The Division of Planning, Evaluation and Information Technology is dedicated to the ongoing development and use of information technology in support of quality improvement, performance accountability, and data-based decision-making statewide and for each OMH region, LGE, and state hospital. The Division continues to support and develop a comprehensive, integrated web-based information system (OMH-IIS: Office of Mental Health Integrated Information System), progressing towards a complete electronic client record. The Division has continued to enhance the OMH data

Warehouse and decision support system (Decision Support On-line) for statewide client-level administrative data, the consumer quality-of-care survey program (using standard MHSIP-based questionnaires), and the Quarterly Report of Quality Performance Indicators, which is reviewed at the Quality Forum sponsored by the OMH Quality Council. OMH recently focused efforts on implementing systems to support the Cornerstone Utilization Management Program, including the adult Level of Care Utilization System (LOCUS), electronic Centralized Scheduling, and client-level outcome monitoring.

Psychosocial Outcomes Monitoring Scales (POMS)

The Office of Mental Health has developed a tool for measuring outcomes of clients receiving services in its mental health centers. The POMS is administered to adult clients by specially trained clinicians at admission, every 6 months during treatment and at discharge or any change to another level of care. This instrument allows the Office to collect data that can be used to determine effectiveness of services delivered as well to report on indicators for the Block Grant, the SAMHSA National Outcomes Measures (NOMS), and for reporting on indicators to the Louisiana legislature. A self-report version of this instrument was developed and briefly field tested. Prior to implementation, OMH embarked on a transformation of its service delivery system based on a Utilization Management (UM) model. Within this context, data that was normally collected at baseline by the POMS, will now be embedded within the new process of screening and assessment under UM. In addition, OMH is planning to pilot a web-based version of an outcome monitoring tool, referred to as TeleSage, which may eliminate the need to embed the POMS items in the screening and assessment process and which can also be used to capture outcome information on youth. The alternative will be to use the most recently developed self-report version of the youth POMS (Y-POMS) to capture outcome data on the youth population.

Judicially involved children and youth who require mental health services are addressed

Judicially involved children and youth who require mental health services continue to be addressed. Legal procedures have been developed to provide for sanity hearings for juveniles who are transferred to adult criminal court. These juveniles will be directly assisted with age-appropriate methods in the determination and restoration of the capacity to proceed to trial. The Department of Health and Hospitals has developed and continues to revise rules and regulations for certifying restoration providers and has developed a training module patterned after national best practices. Louisiana continues the study of issues relating to juvenile competency through the Juvenile Justice Task Force extending the period of time for the study. The Louisiana State Law Institute's Subcommittee on the Children's Code continues to meet to study the issues and develop additional legislation.

Cultural and Linguistic Competence Planning Committee

This committee guides, monitors and evaluates cultural and linguistic competence so that citizens can receive appropriate services. The committee's initial work began in April, 2005, but the direction of the committee was altered after the hurricanes. After the storms, the committee realigned its priorities and developed a Cultural Competence Plan for Louisiana Spirit. Initial cultural and linguistic competence training sessions for the Louisiana Spirit staff occurred in August, 2006. Trainings were again held in May, July, and November, 2007. Training is scheduled in August, 2008 to provide new employees with this knowledge.

Office of Client, Youth & Family Affairs

This office continues to actively work towards the development and statewide implementation of peer support programs, resource or drop-in-centers, and the coordination of a statewide advocacy network, in addition to other initiatives that seek to encourage consumer/family choice and empowerment throughout the system of care as Louisiana moves towards a recovery modality. As of 2008, the Office of Mental Health began the process of implementing Peer Support Services throughout the state of Louisiana, using the curriculum developed by Recovery Opportunity Center, formerly known as META Services. The ultimate goal of this program is to employ a variety of Peer Specialists in various capacities throughout the system of care. At the end of September 2008, there will be approximately 40 trained and certified Peer Support Specialists, many of whom will be employed in full or part-time positions. Beyond September, it is the goal of the Office of Mental Health to continue to fully support and certify peers and to ultimately train peers as trainers so that the program can achieve long-term sustainability. In addition to certifying Peers as Support Specialists the Office of Mental Health is educating direct care staff in recovery and leadership in an effort to bring forward to a greater degree recovery methodology and the inclusion of peers.

Disaster Recovery and Preparedness

State, regional, and hospital disaster recovery and emergency preparedness plans ensuring maximum interagency collaboration are continually being evaluated and refined. The staff of OMH is committed to benefiting from the lessons learned during Hurricanes Katrina and Rita. To this end, OMH continues developing disaster response and recovery plans that build on partnerships, both public and private.

Transition to Local Governing Entities (LGEs)

Legislation was passed during the 2006 legislative session calling for DHH to develop a plan to facilitate the remaining 6 geographic regions to transition to local governing health care districts or authorities. Local governing entities (LGEs) have the responsibility for providing services to persons with mental illness, substance use and abuse disorders, and developmental disabilities. The Department of Health and Hospitals, along with the three program offices of Mental Health, Addictive Disorders and Developmental Disabilities together will review and modify the current organizational structure and align leadership to achieve strategic directions and support transition to Human Service Districts.

Governor's Health Care Reform

During 2004, Governor Kathleen Babineaux Blanco initiated a comprehensive health planning process to include input from communities across Louisiana. The Governor's Health Summit prompted the development of the Department of Health and Hospital's (DHH) Strategic Plan, and the resulting Transition Plan in OMH. In June of 2005, *A Report on the State of the Mental Health Delivery System in Louisiana* was presented to the Governor's Health Care Reform Panel. Included in this report is the acknowledgement that in order for meaningful progress to occur, reform must take a broad coordinated approach involving federal, state, and local governments, public/ private partnerships and citizens coming together. Out of this activity came a Governor's Executive Order for Louisiana under the leadership of DHH to develop a comprehensive transition plan for the Louisiana's mental health system. This plan is discussed in detail in Part C, Section II, titled *Louisiana's Plan for Access to Mental Health Care*

- The Office of Mental Health is committed to the development and subsequent implementation of this plan which significantly changes how mental health is viewed in Louisiana and how services essential to positive mental health and quality mental health treatment are delivered.
- The plan is undergoing review within the administration of Governor Bobby Jindal, who took office in January of 2008.

OFFICE OF MENTAL HEALTH

VISION

We envision a future in Louisiana where every individual has the opportunity to live a full, satisfying, and productive life in their community.

MISSION

OMH will advance a *Resiliency, Recovery* and Consumer focused system of person centered care utilizing best practices and evidence based practices that are effective and efficient as supported by data from measuring outcomes, quality and accountability.

OFFICE OF MENTAL HEALTH PRIORITIES

TEN PRIORITIES FOR A RESILIENCY/ RECOVERY SYSTEM OF CARE IN CONCERT WITH CONSUMER AND STAKEHOLDER RECOMMENDATIONS
1. Serving youth, adults, and families affected by serious mental health and co-occurring disorders (MH/AD/DD) with Best Practices and Evidence Based Practices 2. Improving access (entry) to care through an integrated health care system 3. Reducing stigma 4. Using Utilization Management to ensure people receive the right care 5. Increasing Cultural and Linguistic Competency 6. Competency in coordinating care for high end users (most seriously ill) 7. Ensuring the use of valid and reliable data in decision making 8. Provision of training, skills assessment, re-training, monitoring, and outcome/ quality measures. 9. Manualization of practices 10. Focusing on Prevention and Early Intervention

LOUISIANA FY 2008
BLOCK GRANT PLAN

Part C
STATE PLAN
Section III

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

ADULT PLAN

EMERGENCY RESPONSE

Louisiana Spirit Hurricane Recovery Crisis Counseling Program

Louisiana Spirit is a series of FEMA/SAMHSA service grants funded through the Federal Emergency Management Agency and administered through the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The Louisiana Office of Mental Health was awarded a federal grant for the Crisis Counseling Assistance and Training Program (CCP) in Louisiana, which focuses on addressing post hurricane disaster mental health needs and other long term disaster recovery initiatives, in coordination with other state and local resources. Crisis Counseling Programs are an integral feature of every disaster recovery effort and Louisiana has used the CCP model following major disasters in the state since Hurricane Andrew in 1992.

The CCP is implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA). Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974 authorizes FEMA to fund mental health assistance and training activities in areas which have been Presidentially declared a disaster.

These supplemental funds are available to State Mental Health Authorities through two grant mechanisms: (1) the Immediate Services Program (ISP) which provides funds for up to 60 days of services immediate following a disaster declaration; and (2) The Regular Services Program (RSP) that provides funds for up to nine months following a disaster declaration. Only a State or federally-recognized Indian tribe may apply for a crisis counseling grant.

Upon receiving the Presidential disaster declaration, OMH conducted a needs assessment to determine the level of stress being experienced by disaster victims and determined that existing State and local resources could not meet these needs. Subsequently, Louisiana immediately applied for a Crisis Counseling grant in response to the impact of Hurricane Katrina and later Hurricane Rita. Louisiana Spirit funds are targeted to the residents of all 64 parishes affected by the devastation of Hurricanes Katrina and Rita.

Disaster mental health interventions include outreach and education for disaster survivors, their families, local government, rescuers, disaster service workers, business owners, religious groups and other special populations. CCPs are primarily geared toward assisting individuals in coping with the extraordinary stress caused by the disaster and connecting them to existing community resources.

The CCP does not provide long term, formal mental health services such as medications, office-based therapy, diagnostic and assessment services, psychiatric treatment, substance abuse treatment or case management; survivors are referred to other entities for these services. CCPs provide short-term interventions with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. Community outreach is the primary method of delivering crisis counseling services and it consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services Crisis counseling

services include: Information/Education Dissemination, Psychological First Aid, Crisis/Trauma Counseling, Grief & Loss Counseling, Supportive Counseling, Resiliency Support, Psychosocial Education, and Community Level Education & Training.

Louisiana Spirit Hurricane Recovery program consists of three separate grants and currently employs a diverse workforce of approximately 466 staff members, primarily Outreach Workers. Included are several sub-grantee agencies: Louisiana State University Health Science Center (LSUHSC) Department of Psychiatry, Harmony Family Support & Outreach Services, Options for Independence, and Volunteers of America of Greater Baton Rouge, and Volunteers of America of Greater New Orleans. Each agency works in a designated service area. Management and oversight of the program is provided by a state-level executive team dedicated to the support of all operations of the project.

Louisiana Spirit is designed to facilitate integration with other recovery initiatives, rather than compete with them. Therefore, the Louisiana Spirit state-level organizational structure is designed to continuously be in contact with recovery initiatives throughout Louisiana and coordinate its activities with these other recovery operations. Community Cultural Liaisons at the provider and state levels work to continuously keep up with changing community resources to share with survivors and other community entities.

The goal of Louisiana Spirit is to deliver services to large numbers of residents who are diverse in age, ethnicity, and needs. Extensive ongoing evaluation of the program includes assessment of the services provided, the quality of the services provided, the extent of community engagement, and monitoring of the health and recovery of the entire population. The evaluation plan for Louisiana Spirit is multifaceted to reflect the ecological nature of the program seeking to promote recovery among individuals, communities, and the entire population of Louisiana. The assessment component of Louisiana Spirit hopes to answer the question of not only the absolute number of people served but how the services are distributed across geographic areas, demographic groups, risk categories and time. To this end, each of the state-level administrative staff members is responsible for ensuring fidelity to the CCP model and expectations as directed by SAMHSA/ FEMA.

SAMHSA/ FEMA also requires CCPs to collect information to provide a narrative history-a record of program activities, accomplishments and expenditures. Louisiana Spirit collects data on a weekly basis from all providers which is analyzed by the Evaluation Director and also sent to SAMHSA for further analysis and comparison with data from all the other Immediate Services Program and Regular services Program Crisis Counseling Programs in the nation. Since September 2006, over 327,446 individual visits have been made, with 187,392 of the visits occurring during the 2007-2008 fiscal year.

To help to monitor geographic dispersion/reach/engagement, the number of individual and group counseling encounters for a given week/month/quarter are tallied by zip code and displayed graphically as a check of whether communities are being reached in accord with the program plan and community composition. To monitor demographic dispersion/reach/engagement, the individual encounter data has been broken down by race, ethnicity and preferred language as one indicator of how well the program is reaching and engaging targeted populations. Similarly, the individual and group encounter data can be analyzed according to risk categories, such as rescue/recovery, bereavement, displacement, or pre-existing mental health problem, therefore allowing the program to use the data in real time to determine how well they are reaching groups who would predictably

need particular services. In addition, a voluntary anonymous participant survey has been used to add depth to the information about the individuals participating in the individual and group counseling encounters such as the severity of the participant's exposure, current problems, and their satisfaction with services.

Federal funding for the Louisiana Spirit program from FEMA is scheduled to end December 31, 2008, making it one of the longest post-disaster FEMA funded crisis counseling programs in history.

Social Services Block Grant

The Social Services Block Grant (SSBG) was awarded to Louisiana following Hurricanes Katrina and Rita in 2005. Almost $65M was allocated for mental health services. The SSBG funds were used to sustain programs that were vulnerable following the disaster and to initiate new services needed as a result of the hurricanes. The SSBG funded programs included extensive crisis services for adults, and school-based and enhanced crisis services for children and youth. The services were provided to those directly and indirectly impacted by Hurricanes Katrina and Rita, in addition to those with SMI and EBD. Funds were also used in several Regions and Districts to provide services to people who do not meet the criteria for SMI or EBD, but were in need of some form of mental health intervention related to the aftermath of the hurricanes. Many of the programs initiated with SSBG have now been funded with state general funds, assuring sustainability beyond the grant period which has ended. The grant period ends in September of 2008.

HEALTH, MENTAL HEALTH, MH REHABILITATION SERVICES & CASE MANAGEMENT

FY 2009 - ADULT PLAN

Individuals with Serious Mental Illnesses often have co-occurring chronic medical problems. Therefore, it is important to enhance a collaborative network of primary health care providers within the total system of care. The Office of Mental Health continues to develop holistic initiatives that offer comprehensive and blended services for vulnerable children and adults experiencing psychiatric and physical trauma including those in acute crisis. In addition, Louisiana's extensive system of public general hospitals provides medical care for many of the state's indigent population, most of whom have historically had no primary physician. In the past few years, most of OMH's acute psychiatric inpatient services have been provided in Louisiana Health Sciences Center-Health Care Services Division (LSUHSC-HCSD), and LSU Shreveport public general hospitals. Over the next several years, there may be more acute units moved under the LSU umbrella. Through collegial discussions with LSU, both parties believe that continuity of care is often better served with this relationship and that those persons admitted with acute psychiatric problems might then receive the best *physical* assessment and treatment as well as care for their psychiatric problems. Adults who are clients of state operated mental health clinics or Medicaid funded Mental Health Rehabilitation (MHR) Services also benefit from a systematic health screening. The OMH clinics work very closely with private health providers as well as those within the LSUHSC-HCSD. Further, MHR providers who provide services to children, youth, and adults must assure through their assessment and service plan process that the whole health needs of their clients are being addressed in order to get authorization for the delivery of services through the Medicaid/OMH Behavioral Healthcare Unit.

Outpatient mental health services have historically been provided through a network of approximately 43 licensed community mental health centers (CMHCs) and their 26 outreach clinics. These are located throughout OMH geographic regions and LGEs. The CMHC facilities provide an array of services including: screening and assessment; emergency crisis care; individual evaluation and treatment; medication administration and management; clinical casework services; specialized services for children and adolescents; and in some areas, specialized services for those in the criminal justice system.

The CMHCs serve as the single point of entry for acute psychiatric units located in public general hospitals and for state hospital inpatient services. All CMHCs operate at least 8 a.m. - 4:30 p.m., five days a week, while many are open additional hours based on local need. CMHCs provide additional services through contracts with private agencies for services such as Assertive Community Treatment (ACT) type programs, case management, consumer drop-in centers, etc. OMH is cognizant of the fact that some of these services are limited and not available statewide, and attempts to improve access are being made.

Although the CMHC's operate with somewhat traditional hours, crisis services are provided on a 24-hour basis. These services are designed to provide a quick and appropriate response to individuals who are experiencing acute distress. Services include telephone counseling and referrals, face-to-face screening and assessment, community housing for stabilization, crisis respite in some areas, and access to inpatient care.

The Mental Health Rehabilitation (MHR) program provides services in the community to adults with serious mental illness, and, like other mental health services, was also affected by the storms of 2005. While the program is a Medicaid program, the Office of Mental Health provides utilization management activities through a Memorandum of Understanding with Medicaid. These activities include authorization of services, monitoring and enrollment of providers and training of providers.

Efforts to improve the Mental Health Rehabilitation optional Medicaid program continued through FY 2008. The core improvements included the continued development of best practice services, new eligibility criteria, and a fee-for-service reimbursement model. These changes began in 2003 when OMH and the Medicaid office contracted with the Technical Assistance Collaborative to update the mental health rehabilitation services. Implementation of many of the new services occurred on August 1, 2005. Treatment approaches for adults include:

- Assessment/Reassessment
- Community Support – Each adult has a community support worker who assures coordination of care and access to services. The community support worker also provides specific skills training to assist with socialization and adaptation skills. Community Support workers fulfill the case management function for the service system.
- Group Psychosocial Skills Training – This program is based on a psychosocial rehabilitation philosophy to assist persons with significant psychiatric disabilities to increase their functioning to live successfully in the environment of their choice. The service integrates recovery and rehabilitation principles into the daily activities of the recipient.
- Counseling (Individual, Group and Family)
- Medication Management

Providers and Prior Authorization staff members have received training in the new MHR program. Training continues to focus on new service requirements, the business model of the new program, level of care scales, the assessment process, and new software. A plan for quality improvement was

developed for the Prior Authorization program and continues to be refined. The purpose of the QM program is to ensure consistency in Prior Authorization decision making, as well as to establish internal and external performance standards. Program fidelity protocols are being established for MHR services to ensure compliance with program requirements.

All authorized providers in the network have been accredited by JCAHO, CARF, or COA as of March 31, 2006. Ongoing training by the MHR Provider Training unit continues, providing updated information on conducting assessments, performing LOCUS and CALOCUS screenings, and other technical issues. Regular face to face meetings with members of the provider network are held statewide on a quarterly basis. Physician/Psychiatrist review continues within the Prior Authorization Unit, and an extensive and thorough redesign and enhancement to the administrative structure and operations of all aspects of the program is fully underway with the assistance of the National Council of Community Behavioral Healthcare.

The table below shows pertinent facts about the utilization of the MHR program. How the changes in the MHR program will affect the delivery of services long-term is yet to be determined.

Number Receiving Mental Health Rehabilitation Services

	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Children: Medicaid Funded	3,676	3,961	5,080	4,886	4,201	4,539
Adults: Medicaid Funded	2,412	2,265	2,506	2,379	1,605	1,459
TOTAL	6,088	6,226	7,586	7,265	5,806	5,998

Mental Health Rehabilitation Budget Figures

	FY 02-03	FY 03-04	FY 04-05*	FY 05-06	FY 06-07	FY 07-08
Medicaid Payments to public and private providers	$38,890,461	$49,053,440	$59,341,261	$27,874,936	$25,439,197	$30,977,478
Medicaid to OMH for Administrative Case Management	$724,022	$380,956	$829,288	$1,509,961*	$1,053,719	Not available

NOTE: based on amount that has been released for payment at end of Fiscal Year
* Includes PA, Pelican Project Monitors, and Medical Review

Mental Health Rehabilitation Providers

	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Medicaid Mental Health Rehabilitation Agencies Active During FY	110	128	124	114	77	61

EMPLOYMENT SERVICES
FY 2009 - ADULT PLAN

The Office of Mental Health (OMH) recognizes that work is a major component in the recovery process and supports consumers who have work as a goal. OMH has utilized Employment Specialist training and other related employment training available through The University of North Texas & the Federal Region VI Community Rehabilitation Continuing Education Program to build a cadre of trained Employment Coordinators in each Region. At this time however, most Regional Employment Coordinators have additional duties and on average devote less than 25% of their time to employment issues. This has served to hamper OMH efforts to increase employment initiatives. Several regions have expressed an interest in hiring full time employment coordinators and are working towards doing so.

To expand employment of persons with severe mental illness, OMH has promoted a strategy to actively seek and access opportunities external to OMH at the state and federal level to fund the further development of such services which expand employment opportunities. Such external opportunities may include, but are not limited to monies available for employment, employment services related to housing support, vocational rehabilitation services, and related employment services. Such funds are available through the Social Security Administration, HUD, Department of Labor WorkFORCE Development, the Rehabilitation Services Administration, and other Federal and state programs. The passage of the Federal Ticket to Work Program and the Work Incentives Improvement Act of 1999 make a large pool of federal dollars available for development of these employment related services.

OMH also has active linkages to, and representatives serving on the advisory bodies of, the Louisiana Medicaid Purchase Plan, Social Security Administration Benefits Planning Grant, Department of Labor One-Stop Accessibility Grant, Ticket-To-Work grant opportunities, and other employment related national and state public/private funding resources.

OMH Employment Liaisons and Consumer Liaisons continue to receive training in Benefits Planning, One-Stop, and Ticket-To-Work topics relevant to mental health consumers through Social Security Benefits Planning and the Department of Labor. Staff members from the Louisiana Rehabilitation Services State Office (the State Vocational Rehabilitation Agency - LRS), and members of the field staff attend these meetings and trainings. University of North Texas has been brought to Louisiana to train both LRS and OMH staff on issues related to employment, recovery and evidence based practices. This joint training is done on a regional basis and in addition to education is intended to strengthen relationships and overcome any barriers to successfully collaborating on the employment of individuals with psychiatric disabilities.

OMH has participated in the development and implementation of Supported Self-Employment (Micro enterprise) pilots in different regions of the state, and in the previous development and establishment of intensive employment placement and support pilots (Employment Recovery Teams) in two regions. OMH has also supported the implementation of an employment program through the Jefferson Parish Human Services Authority's community mental health center. The program continues with great success as the JPHSA staff collaborates with LRS, DOL and the Career Solution Centers, as well as actively works with their clinician pushing employment as a path to recovery.

Joint OMH-LRS efforts are aimed at offering consumers intensive individualized supports in order to assist them in seeking, finding, obtaining, and keeping employment in community based competitive jobs and/ or self-employment. A joint LRS-OMH agreement spells out each party's areas of responsibility and supports regular collaboration between the agencies. OMH has conducted Area Employment Needs Assessments with collaborative participation by LRS in each Area, and engages in routine joint regional meetings to: assess each Area's current employment initiatives; determine needs for enhancement/creation of new employment programs/opportunities for consumers; share information on current and planned OMH employment projects; develop/enhance cooperation with LRS and private employment providers; develop a database of employment related resources for each Region/Area.

The Louisiana Commission on the Employment of Mental Health Consumers was originally created in the 2004 legislative session, in response to several state and federal initiatives including the *Presidents New Freedom Commission* Report and Louisiana Office of Mental Health's Project Legacy. The Employment Commission was created to explore barriers to the employment of individuals with psychiatric disabilities and solutions to those barriers. It was legislatively comprised of 20 entities, with additional organizations being invited to participate. Though the Commission sunsetted in June, 2007, the recommendations were reiterated through goal 5 of Louisiana's Plan for Access to Mental Health Care which was developed through Executive Order KBB 05-16, and published in June, 2007.

Employment continues to be problematic in Louisiana, for a variety of reasons, not the least of which is the record high price of gasoline, making transportation to and from a job sometimes cost-prohibitive.

The Louisiana HIRE, an IPS program in CAHSD reported experiencing an increased need for employment services, and has placed 35 individuals. Region 4 reported that they will be initiating an IPS model of employment in conjunction with Louisiana Rehabilitation Services. Overall, the Lafayette area has seen their unemployment rate drop due to the influx of hurricane evacuees into the region. Businesses are reporting a difficult time recruiting qualified personnel for job vacancies.

As previously noted, population shifts have caused employment problems. Region 6 reports an influx of consumers into their region, and due to competition for jobs, it is more difficult than ever for consumers to find jobs. Region 5 lost its OMH funded employment program following the hurricanes due to a loss of funding. The funding was restored with SSBG funds; however, it has been difficult to replace lost staff members since the hurricanes. Region 7 reports that all staff members are involved in preparing consumers for work, and they have had success in utilizing a program similar to the IPS program, that consists of innovative programming including Vocational readiness training, resume building, wardrobe and interview skills. Goals for consumers include both volunteer and paid employment.

Region 8 will have a Supported Employment program with Goodwill Industries beginning in the summer of 2008. FPHSA also notes that because several group homes have closed, there has been a decrease in the availability of job coaching and support for individuals who previously lived in these group homes.

Through these varied means, the overall goal of OMH employment initiatives is to create a system within the Office of Mental Health that will encourage and facilitate consumers of mental health services to become employed, thereby achieving greater self-determination and a higher quality of

life, while helping consumers transition from being dependent on taxpayer supported programs; to being independent, taxpaying citizens contributing to the economic growth of our state and society.

Employment Programs Serving SMI by Region – FY 08

REGION / LGE	TYPE OF EMPLOYMENT SERVICE	NUMBER SMI SERVED	NUMBER SMI PLACED
MHSD*	Employment Pre-Employment Training Individual Placement and Support (IPS)	60	5
CAHSD	Individual Placement and Support (IPS)	46	35
III	Employment/Pre-Employment Training	167	77
IV	Transitional Employment	14	14
V	Employment/Pre-Employment Training,	15	3
VI	Employment Referral, Employment/Pre-Employment Training, Individual Placement and Support (IPS)	35	7
VII	Employment Referral, Employment/ Pre-employment Training, Supported Employment, Transitional Employment, Individual Placement and Support (IPS)	291	50
VIII	Transitional Employment, Individual Placement and Support (IPS)	35	14
FPHSA	Employment Referral Transitional Employment	31	1
JPHSA	Supported Employment	153	81
TOTAL*		**847**	**287**

*** NOTE: Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

HOUSING SERVICES
FY 2009 - ADULT PLAN

As with employment services described previously, the MHR, case management, and ACT programs are very involved in assisting consumers and families with opportunities to secure and maintain adequate housing. Furthermore, in keeping with the use of best practices and consumer and family choice described in criteria 2 and 5 of the *President's New Freedom Commission Report*, OMH has a strong commitment to keeping families together, and to increasing the stock of permanent supportive housing; and consequently has previously withstood pressure to fund large residential treatment centers. Instead, effort and dollars have been put into Family Support Services, housing with individualized in home supports, and other community based services throughout the state. The consumer care resources provide highly individualized services that assist families in their housing needs. OMH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has actively pursued the inclusion of people with disabilities in all post-disaster affordable housing development. These efforts resulted in a Permanent Supportive Housing (PSH) Initiative which successfully gained a set aside of 5% of all units developed through a combination of disaster-related housing development programs (including Low Income Housing Tax Credits) targeted to low income people with disabilities.

Congress recently approved funding for 3,000 rental vouchers to go to participants in the PSH program, furthering the goal of serving 3,000 people. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative will also target the aging population so those persons with mental illness who are in that subpopulation will have targeted housing.

Of particular note has been the OMH pursuit of State General Funds for housing and support services. OMH was successful in obtaining funding sufficient to develop housing support services for 600 adults with mental illness (60 for each of the 10 planning regions) and 24 hour residential care beds to serve 100 people (10 for each of the 10 planning regions) in 2006. Because housing costs have increased so dramatically due to the loss of housing stock from hurricanes Katrina and Rita, OMH requested, but did not receive, funding for rental subsidies in the 2007 budget. In February of 2008, an Executive Order was issued by the Governor in response to the overwhelming need for mental health services in New Orleans. In response, to this, a plan was developed by the Department of Health and Hospitals to provide immediate assistance to the mental health delivery system in New Orleans. The plan consisted of eleven immediate action items. One of the items is a rental assistance program which will fund 300 housing subsidies to individuals, some of whom are homeless with serious mental illness and co-occurring disorders. State General Funds in the amount of $2,880,000 will fund the housing subsidies for FY 08-09. A total of $18,271,140 will be used to fund all of the items (including housing subsidies) in the plan in FY 08-09.

The state has continued to pursue housing resources through the HUD funding streams such as the Continuum of Care for the Homeless program and the Section 811 and Section 8 programs over the past ten years. While shifts in HUD policy have created barriers to persons with mental illness qualifying for housing resources through the Continuum of Care, and the Section 811 and Section 8 programs have been severely reduced, the HUD programs continue to be a focus of development activities. OMH Regional Housing Coordinators are active participants in the regional housing/homeless coalitions. In some cases these coordinators are in leadership positions in their local coalitions. Service providers have pursued Section 811 applications and sought to develop fruitful relationships with local housing authorities to pursue rental vouchers. Federal applications for housing and support services submitted by mental health providers have increased over the years as agencies search for avenues to develop housing and support services for the mental health consumers they serve.

The Louisiana Housing Trust Fund was allocated $25 million by the Louisiana legislature in 2007. Guidelines were established and it was decided that 30% of these funds would be set aside for households who are at or below 30% median income. This could include housing for the homeless and Permanent Supportive Housing. In 2008, an application was developed and distributed. The application deadline was June 30, 2008.

It is obvious that there is much activity in seeking assistance with housing for individuals with SMI. Many successful programs to assist individuals with housing needs are operating in each Region and LGE as can be seen in the table below:

Housing Assistance Programs by Region/ Local Governing Entity (LGE)

Region/ LGE	# of Programs	# Referred Unduplicated	# Placed Unduplicated
MHSD*	10 programs	unk	unk
CAHSD	4 programs	63	63
Region III	9 programs	509	233
Region IV	5 programs	235	149
Region V	10 programs	70	80
Region VI	8 programs	259	80
Region VII	10 programs	341	198
Region VIII	7 programs	138	74
FPHSA	5 programs	Unk	Unk
JPHSA	10 programs	976	432

*** NOTE: Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

Although the hurricanes of 2005 displaced a record number of people to localities outside of Louisiana, the number of homeless people with mental illness is not reduced along with the general population reduction. Instead, the number of homeless individuals is slightly larger than pre-disaster estimates would indicate. An already critical shortage of affordable housing was exacerbated by the hurricanes. This is true of the general population in Louisiana and the resulting demand has escalated housing costs further. The public mental health reporting system revealed that as of June 30, 2006, 5,824 clients were homeless and of that number 2,946 were displaced by the hurricanes. In the OMH Projects for Assistance in the Transition from Homelessness (PATH) annual report, it is noted that for the state fiscal year July 2006 through June 2007, 4,977 persons were served who have a mental illness and were homeless. *New Orleans Unity*, a non-profit organization for the homeless, estimates that there are 12,000 homeless and approximately 40% or 4,800 have a mental illness. Recent information from the Department of Social Services indicates that there are 12,089 occupied FEMA trailers statewide. The breakdown is: Commercial sites: 381 owners & 726 renters; Group sites: 77 owners & 132 renters; and Private sites-8,184 owners & 2,589 renters.

Individuals with financial concerns, including many people with disabilities, are having an increasingly difficult time in retaining their housing and are at risk for homelessness. Those already homeless are facing significant barriers to obtaining housing they can afford. According to the National Low Income Housing Coalition, in Louisiana the Fair Market Rent for a two bedroom apartment is $746.00. In order to afford this level of rent and utilities without paying more than 30% of income on housing, an hourly work wage of $14.34 is required.

JPHSA noted that rental pricing is the prohibitive factor in many residents inability to return to New Orleans. In the current housing market individuals who receive SSI/SSD benefits would be required to spend their entire monthly allotment on housing alone. It is also noted that shelter and transitional housing beds are scarce. CAHSD reports that the hurricanes have continued to impact their region due to the shortage of affordable rental housing and through the increases in poverty related to lack of livable wage employment. According to the 2007 Point in Time Survey conducted by the Capital Area Alliance for the Homeless, which serves the same seven parishes as

CAHSD, of the 1100 people who participated in the survey and responded to the question, 320 people (29%) reported being displaced by Hurricane Katrina or Rita.

Region 3 reports that housing referrals are down 21% from the previous year, suggesting that some stabilization has occurred. Region 5 reported that following Hurricane Katrina, the number of evacuees totaled over 10,000 straining the very areas where Hurricane Rita hit shortly thereafter. Rents were often too high for the subsidized housing Section 8 program, leaving many people homeless. Region 6 reports that housing continues to be an issue due to the influx of people evacuating from hurricane affected areas.

In summary, the need for housing services has increased, and available community placements have decreased due to the hurricanes. It is also noted that many evacuees are living with friends or family while waiting for housing; and thousands of people across the state are still in FEMA trailers. Other issues, programs, and initiatives related to housing are discussed in the Homeless Outreach section of this application (Criterion 4).

EDUCATIONAL SERVICES
FY 2009 - ADULT PLAN

Louisiana OMH Supported Education is a program based on a 1997 OMH/LSU joint research project concerning theories and models of Supported Education nationwide, and development of a '*Louisiana Model*' for Supported Education based on that research. The Louisiana Office of Mental Health initially funded Louisiana State University's (LSU) Supported Education Program for students with serious mental illness (SMI). In keeping with Goal #1 of the *President's New Freedom Commission Report*, stating that Americans understand that mental health is essential to overall health, supported education became a part of the disability program at LSU forcing recognition that mental health is as important as physical health to the well-being of college students. Nationwide, LSU became one of the first four year universities and colleges to have a supported education program in place and operational, with initiation of the program in the Spring Semester of 1997. Following the successful operation of the LSU program for three years, and upon LSU's agreement to continue the program, OMH then moved the funding to the University of Louisiana at Lafayette (ULL). The ULL program became operational in the Fall Semester of 2000, with the University being fully able to sustain it internally as of 2006. Both LSU and ULL received funding with OMH Block Grant monies to establish a Supported Education Advisor position within each university's existing services for students with disabilities. The Supported Education Advisor only serves those students identifying themselves as persons with Serious Mental Illness (SMI), and who met the OMH definition for SMI, emphasizing that mental health care is consumer and family driven, as posited in the *President's New Freedom Commission Report*, Goal #2.

Both universities agreed to contribute in-kind resources for the program and to continue the programs funding once the OMH "seed money" ended, as well as to assist the transfer of supported education technology to other Louisiana institutions of higher learning. Funds were utilized during the 2007/08 fiscal year for continuing education opportunities for the Supported Education Coordinators at both LSU and ULL. In addition, funds were utilized to sponsor a statewide seminar on supported education and best practices for serving this population through the various disability affairs offices. The seminar was well received with representation from Colleges and Universities throughout the state. National leaders in Supported Education were brought in to present on topics related to needed supports/accommodations, education on supported education and fidelity to the model. The seminar was intended to generate interest and improve services for individuals with

psychiatric disabilities in the post-secondary educational setting. OMH continues to provide supports to LSU and ULL to ensure program efficacy, while strengthening capacity for serving this population in other institutions of higher learning.

The OMH sponsored supported education programs at LSU and ULL provide both individual and group support to students with serious mental illness pursuing post-secondary education. Students also receive assistance with needed accommodations under ADA, as well as disability management counseling and information/referral to on and off campus agencies. The Supported Education Advisor serves as a case manager for students with SMI; is a liaison to the student's primary therapist; and serves as an on-campus advocate. The focus is on attempting to minimize the impact of a student's psychiatric illness by determining what accommodations are needed in order for the student to successfully handle both academics and adaptation to the social milieu of the university. The long-term goal of the program is to see the student with SMI successfully complete a university education and enter the world of work in a career field of the student's choice. The program targets students with SMI of all ages, both those who are older and are (re) entering a secondary educational setting after years of mental health treatment, as well as those who are younger and may be experiencing psychiatric symptomatology for the first time. Thus the goal of the program is achieved through both funneling individuals back into the educational system as well as maintaining them there as they cope with the onset of their mental illness. These goals fall in line with the *President's New Freedom Commission* for Mental Health through its call for quality community based services, improved transition services and promotion of innovative and effective services such as supported education which are specifically targeted towards individuals with SMI.

Referrals to the program come from a variety of sources, including: OMH Mental Health Clinics, the on-campus Mental Health Services of the universities, Louisiana Rehabilitation Services, and University faculty and staff. The largest referral source, however, continues to be self-referral by SMI students enrolled at LSU and ULL who have been made aware of the program. Satisfaction surveys administered to students receiving services at LSU and ULL indicate a high level of satisfaction with services received. Though there had been a decrease in the numbers of those enrolled immediately following the storms, the numbers have since rebounded to pre-storm levels. The table below shows the growth and success of the program. Both schools continue to do satisfaction surveys with current students, and follow-up with those who have graduated.

SUPPORTED EDUCATION PROGRAMS 2005-06, 2006-07, and 2007-08

	LSU 2005-06	**LSU 2006-07**	**LSU** 2007-08**	**ULL 2005-06**	**ULL 2006-07**	**ULL 2007-08**
Total # SEP Students Enrolled	116	172	178	128	164	162
# Undergraduates	102	153	N/A	125	155	155
# Graduate Students	14	19	N/A	3	9	7
Mean GPA *	2.80	2.81	N/A	2.53	2.77	2.82
Hours Attempted (avg per student)*	11.14	11.90	N/A	9.1	12.84	12.98
Hours Earned (avg per student) *	10.34	10.97	N/A	7.1	9.65	10.48

*undergraduate

**LSU data was not available for the 2007-08 time period.

The Louisiana Supported Education Program has been recognized as a best practice model. In 2002, LSU and ULL were invited to present on their respective programs at the first National Supported Education Conference at the University of Michigan, Ann Arbor, and then again in 2003. ULL was an invited presenter at the 2005 U.S. Psychiatric Rehabilitation Association Annual Conference.

OMH plans to make the Louisiana Model SEP technology available to other Louisiana post-secondary institutions, including the new Community College system. OMH hopes to further expand this unique and excellent program to be available to all current and future students with SMI in the state who seek to succeed in obtaining a college education; and in access to higher-level vocational endeavors, and to professions that such an education can provide.

SERVICES FOR PERSONS WITH CO-OCCURRING DISORDERS (SUBSTANCE ABUSE/ MENTAL HEALTH) AND OTHER SUBSTANCE ABUSE SERVICES

FY 2009 - ADULT PLAN

The Office of Addictive Disorders (OAD), a sister agency to OMH offers treatment services to both adults and child /youth OMH consumers. In some parts of the state OMH and OAD jointly deliver services to people with co-occurring mental and substance disorders. While parallel or sequential treatment is still a common occurrence, the Louisiana Integrated Treatment Services (LITS) Model has been implemented in an increasing number of treatment facilities. Co-occurring treatment ensures that emphasis is placed on early mental health screening, assessment and referral to services, and eliminating disparities in mental health services as noted in *The President's New Freedom Commission Report* Goals #3 and #4. Through the CoSig Grant, coordinated care is improving, with the commitment from each agency to work towards improving treatment for co-occurring disorders. OAD services include the following:

Outpatient Outpatient treatment services are defined as either:
outpatient or intensive outpatient based on the intensity of the services provided by the particular outpatient program.

Outpatient Treatment (Non-Intensive)

Treatment/recovery/aftercare or rehabilitation services are provided, but the client does not reside in a treatment facility. Clients receive alcoholism and/or drug abuse treatment services including counseling and supportive services, and medication as needed.

Intensive Outpatient Treatment/Day Treatment

Services provided to a client that last three or more hours per day for three or more days per week. A minimum of 9 treatment hours per week must be provided.

Inpatient This modality provides non-acute care and includes a planned and professionally implemented regime for persons suffering from alcohol and/or other addiction problems. It operates 24/7 and provides medical and psychiatric care as warranted.

Residential This is strictly a psychosocial model, based on a 12-step program with no medical or psychiatric care. The program functions 24 hours a day, seven days a week.

Detoxification There are two types of detoxification offered:

Medical detoxification

24/7 medical service providing immediate acute care for the alcoholic/substance abuser at extreme health risk (either from an illness/health problem co morbid with the substance abuse problem, or from medical problems resulting from the process of detoxifying).

Social Detoxification

24/7 service designated for patients who need immediate substance abuse detoxification treatment but are not facing any urgent health problems.

Community-Based Services

Halfway House Services

Provides community-based care and treatment for alcohol/drug abusers in need of transitional arrangements, support and counseling, room and board, social and recreational activities, and vocational opportunities in a moderately structured drug-free environment focused on re-socialization and encouragement to resume independent living and functioning in the community.

Three-Quarter Way House Services

Less structured than a halfway house but provides a support system for the recovering alcoholic and/or substance abuser. Clients are able to function independently in a work situation. The three-quarter-way house functions as a source of peer support and supportive counseling. This level of service is designed to promote the maintenance of the client's level of functioning and prepare him/her for independent living.

Therapeutic Community (TC)

Highly structured environment designed to treat substance abusers that have demonstrated a pattern of recidivism or a need for long-term residential treatment. It is a unique program in that it relies on the social environment to foster change in the client while promoting self-reliance and positive self-image. In general, this program requires a minimum of 12 months duration.

Recovery Homes

Recovery homes are self-run and self-supported houses for recovering substance abusers. OAD supports this continuum of care by contracting with Oxford House, Inc., to establish and manage houses within designated areas of the State. In addition, OAD offers a revolving loan program to support the houses with start-up expenses.

Gambling Services

The Office for Addictive Disorders provides services to problem and compulsive gamblers. These services include the Compulsive Gambling Help Line, outpatient and inpatient treatment services, and compulsive gambling prevention services. The office also provides for research, training and program evaluation for the gambling addiction treatment and prevention community.

As a part of the CoSIG initiative, OAD and OMH are working together to jointly develop a specialized Co-occurring residential unit. This unit will serve to fill a significant void for services that specifically address the complex and acute needs of persons with the combination of severe mental health and severe substance abuse disorders, otherwise conceptualized as the Quadrant IV persons on the Co-occurring Quadrant Model.

OMH already has a successful and productive partnership with the Office of Addictive Disorders for implementation of the Louisiana Integrated Treatment Model (LITS), for serving adults with co-occurring mental and substance disorders. The Louisiana Integrated Treatment Model (LITS) is organized around nine Core Principles (see below) and targets the primary outpatient centers throughout the ten service domains to increase their capacity for providing co-occurring informed services according to the Dual Diagnosis Capability Index. According to this model, clinics are expected to adjust the delivery of their services across seven dimensions including: Program Structure, Program Milieu, Screening & Assessment, Treatment, Continuity of Care, Staffing, and Training.

As a part of the initiative, Louisiana was chosen by SAMHSA as one of ten states to participate in the first National Policy Academy on Co-Occurring Mental and Substance Abuse Disorders. At the Academy, the Louisiana Team used the current LITS grant as a foundation, but broadened the scope of work to include children and youth, as well as partnerships with primary care. The outcome of the Academy was the draft of an action plan that has been used to help guide the initiative. Included in the action plan is the expectation that Louisiana citizens will be provided with an integrated system of healthcare that encompasses all people, including individuals with co-occurring mental and addictive disorders *regardless of age*, who will easily access the full range of services, in order to promote and support their sustained resilience and recovery.

The goal of LITS is to develop a Co-occurring disorders capable system in which all mental health and substance abuse programs should be expected to be "co-occurring disorders capable" (CODC). CODC represents a measurable basic standard of care that would be implemented within the context of existing program requirements with only additional technical assistance and support. The CODC system would be created without significant clinical operational cost and could be reliably assessed through routine program audit such as would occur during licensure review.

Local steering committees have been established to lead local planning, identify technical assistance needs, and guide implementation of integrated treatment services. System-wide and individual beliefs and barriers have been identified. Each group has evaluated the ability of the system to provide enhanced co-occurring informed services. Stakeholders are involved through the establishment of the Client Advisory Board, membership on the Behavioral Healthcare Task Force, and projects with community based organizations. Funding streams are being investigated to support drug screens conducted within the OMH system, and increased physician and medication access in the OAD system. Clinical core competency standards are being developed to support integrated treatment, and on-going specialized support and training will be provided. Integrated management information and program evaluation systems, including a web-based client tracking system, are being developed. Cross agency screening and assessment instruments/protocols are being developed, including the ability to document two primary diagnoses.

The following nine guiding principles have been adopted:
1. Dual diagnosis is an expectation, not an exception.
2. All individuals with co-occurring psychiatric and substance disorders (ICOPSD) are not the same; the national consensus four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level (NASMHPD, 1998).
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an

evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.
4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.
6. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.
7. There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.
8. Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.
9. The system of care operates in partnership with consumers, family members and concerned significant others and a continuous effort is made to involve the individual and the family at the system, program and individual levels.

In the summer of 2005 approximately 1,915 LGE and regional staff members from OMH and OAD participated in the Louisiana Integrated Treatment Services (LITS) Basic Orientation and Training course on treatment of individuals with co-occurring disorders. In the summer of 2006, the series of Advanced LITS trainings was completed. Approximately 2,000 LGE and regional staff members have participated. These trained individuals have an impact on the ability of the direct service agencies to screen, assess, diagnose, treat and refer clients as needed. The summer of 2006 also marked the completion of the baseline fidelity assessments at each of the approximate 40 clinics throughout the state. This was followed up with a LITS State Summit that assisted with the development of local strategic plans for each of the 10 LGEs or Regions.

The following is a list of relevant updates (2007 and 2008) to COSIG:

- Most recently, each of the 10 local Regions/Districts utilized the data derived from their 2006 DDCAT/DDCMHT assessments and developed a local strategic plan for increasing COD capabilities in their respective areas. With technical assistance from the COSIG evaluation team and Dr. Mark McGovern, each area formulated a COD plan and began implementation July 1, 2007. During FY 07/08, the COSIG provided monies to each local area for implementation assistance, i.e. EBP workshops, consultation for program and policy development, COD educational material, etc. In July 2008, follow-up DDCAT/DDCMHT assessments will be conducted in order to evaluate implementation progress.
- Continuation of Behavioral Healthcare Taskforce and adoption of an Integrated Model of treatment. The goal of LITS (LA Integrated Treatment Services) is to develop a Co-occurring Disorders Capable (CODC) System in which all mental health and substance abuse programs should be expected to be capable of appropriately recognizing and dealing with persons with co-occurring disorders.
- A measurable basic standard of care which can be implemented within the context of existing program requirements with additional technical assistance and training support, but

without significant additional clinical operational cost, and can be reliably assessed through routine program audit, such as would occur during licensure review.

- The development and implementation of five COSIG committee work groups: Curriculum Committee, Program Evaluation Committee, Funding Committee, Information Management Committee, and Clinical Protocol Committee

The following Table reflects information gathered from each of the Regions and LGEs regarding their programs related to Co-occurring disorders.

Total Numbers of Persons Served by Category and Region/ LGE (unduplicated) -- FY 2008

Region/ LGE	Screen	Assess	Diagnose	Treat	Refer
MHSD*	2743	2864	2075	2972	125
CAHSD	12256	4459	2813	1978	1582
III	4339	3933	2449	2449	339
IV	1376	1868	1025	680	1127
V	745	506	1663	1662	127
VI	0	0	0	0	90
VII	1450	251	322	243	984
VIII	220	220	220	178	42
FPHSA	355	355	355	0	100
JPHSA**	unavail	1396	923	233	39
CLSH	232	232	232	232	232
ELMHS	380	92	380	92	380
NOAH	469	314	184	168	181
SELH	328	328	328	328	328

NOTES

* **Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

****data is incomplete/ unavailable**

MEDICAL & DENTAL HEALTH SERVICES
FY 2009 - ADULT PLAN

The Office of Mental Health attempts to offer comprehensive medical, psychiatric and dental services to its clients. As noted in the *President's New Freedom Commission Report* Goal #1, mental health is essential to overall health, and as such a holistic approach to treating the individual is critical in a recovery and resiliency environment.

Acute inpatient units are provided primarily in Louisiana Health Sciences Center-Health Care Services Division (LSUHSC-HCSD) and LSU-Shreveport public general hospitals. The location of these units within or in the vicinity of general medical hospitals allows clients access to complete medical services. Intermediate care hospitals all have medical clinics and access to x-ray, laboratory and other medically needed services. Outpatient clients are encouraged to obtain primary care providers for their medical care. Those who do not have the resources to obtain a private provider are referred to the LSU system outpatient clinics. Adults who are clients of state operated mental health clinics or Medicaid funded Mental Health rehab services also benefit from a health screening with a referral as needed.

Proper dental care is increasingly demonstrated to have an important role in both physical and mental health. Dental services are provided at intermediate care hospitals by staff or consulting dentists. Referrals for oral surgery may be made to the LSU operated oral surgery clinics. Some examples of low or no-cost dental services/resources available to OMH outpatient consumers include the Louisiana Donated Dental Services program, the David Raines Medical Clinic in Shreveport, the LSU School of Dentistry, the Lafayette free clinic, and the Louisiana Dental Association

The LSU School of Dentistry (LSUSD) located in New Orleans sustained severe damage from flooding from Hurricane Katrina, and was forced to close, re-opening in the fall of 2007. In addition, various school-based dental clinics in MHSD that offered a full range of services also were destroyed but most have re-opened. LSUSD serves primarily residents from the greater New Orleans area; however, LSUSD satellite clinics serve citizens in other areas of the state. In addition, Earl K. Long Hospital in Baton Rouge provides routine dental care.

The LSU operated hospitals have always struggled to meet the needs of all citizens of Louisiana, but even more so since the storms of 2005. In the 2007 legislative session, funding was earmarked for the rebuilding of a large teaching hospital in New Orleans, but action is still pending on this initiative. Furthermore, legislation was passed to begin to encourage the development of "medical homes"--entities that would serve the primary care needs of Louisiana citizens and ensure proper referral to specialty services. Further legislation resulted in the development of a Quality Forum that will plan, promote, and conduct quality improvement initiatives within the state for health care.

Regions not directly impacted by the hurricanes report an increased demand for medical and dental services due to the influx of evacuees into their areas. Since there has been no increase in staff this has resulted in long waiting periods for patients, who then experience increased anxiety and higher levels of emotional and physical pain. Emergency Department waiting times have dramatically increased. In some regions, hospitals have begun offering some on-site medical services at the mental health clinics to patients who do not have transportation, and nursing staff is often available for general nursing consultation and referrals.

SUPPORT SERVICES
FY 2009 - ADULT PLAN

Louisiana's public mental health system is grounded in the principle that persons with serious mental illness can and do recover. OMH has taken an approach that is consistent with Goal #2 of the *President's New Freedom Commission Report* emphasizing that mental health care is consumer and family driven. The Office of Consumer Affairs, created in 2004, was recently reorganized as the Office of Client, Youth and Family Affairs to develop more inclusive services for all those affected by mental health issues in Louisiana. The full-time Director of this office is an identified consumer. This office continues to actively work towards the development of peer support programs, resource or drop-in-center development, coordination of a statewide advocacy network and other initiatives that encourage consumer and family choice in all aspects of care. For example, in Fiscal Year 2008 and continuing forward, Louisiana is implementing a Peer Specialist Employment Program for consumers funded initially by Block Grant dollars. This program will serve to train and ultimately employ consumers in a variety of settings throughout the state of Louisiana. *Recovery Innovations, formally META Services,* has been identified as the curriculum provider for the initial implementation phases. Additionally, the Office of Mental Health was awarded a grant to implement Wellness Recovery Action Planning (WRAP™), under the auspices of the Copeland Center for Wellness and Recovery. These programs working in conjunction will aid in helping to further realize the vision of Goal #2 of the *President's New Freedom Commission Report* as described above.

In the area of consumer empowerment, OMH has supported a variety of activities that aid consumers and their families. These supported activities include employment, housing, and education; all services described earlier; in addition to providing financial and technical support to consumer and family organizations and their local chapters throughout the state. Self-help educational programs and support groups, funded by the Mental Health Block Grant are organized and run by consumers or family members on an ongoing basis. For example, BRIDGES, modeled after the Journey of Hope program for family members, is a consumer-run enterprise, providing education classes and support programs throughout the State of Louisiana.

In addition to the above activities, OMH hires parents of EBD children, and adult consumers into State jobs as either consumer or family liaisons. These individuals assist other consumers and families to access services as well as provide general education and supportive activities such as accessing consumer and/or family care resources. Consumer resources include flexible funds that families and consumers can utilize to address barriers to care and recovery, in unique ways for that individual or family situation. The Louisiana Commission on the Employment of Mental Health Consumers was originally created in the 2004 legislative session in response to several state and federal initiatives including the *President's New Freedom Commission Report*. This employment group recently completed its tenure after formalizing methods to address employment opportunities for mental health consumers.

The Community Integrated Personal Assistance Services and Supports Project (C-PASS) was a grant awarded to Louisiana by the Centers for Medicare and Medicaid. The purpose of the grant was to develop the framework for a system of personal assistant services for individuals with psychiatric disabilities. This included the development of a curriculum in which a core team of mental health consumers were trained to provide education to personal care attendants and providers. Full implementation of the curriculum occurred at the end of the grant, on March 31, 2007, with a group

of mental health consumers trained and capable of sustaining the program beyond the grant period. The CPASS program was designed to:

- Move towards community-based treatment and services.
- Educate providers on mental health issues, communication strategies and person centered planning/consumer direction.
- Improve the quality of care for individuals with psychiatric disabilities.
- Help individuals with psychiatric disabilities integrate into their communities, including: decreasing hospitalizations (length or frequency of stay); increasing level of functioning/community-involvement; increased employment opportunities resulting in reduction in SS benefits received; and, increased independence.

At the end of the grant period, this program was successfully transitioned to the Mental Health Association of Greater Baton Rouge.

The Office of Mental Health partially or fully funds numerous Consumer Resource Centers (also called Drop-In Centers) that provide not only socialization opportunities, but activities designed to enhance both social and pre-vocational skills. Job Clubs, which prepare consumers to seek employment by offering classes on job search, resume-writing, interview role-playing, etc. are a feature at many of the Resource Centers. Technical skills, such as computer literacy are also offered at Resource Centers. Many of these Consumer Resource Centers are consumer run or administered.

Consumer Resource Centers

Region/ LGE	# of Consumer Resource Centers	Block Grant Funds	Total Funding Includes SGF& other sources	FY 06-07 #served unduplicated
MHSD*	1 Center	$135,119	$135,119	180
CAHSD	4 Centers	140,338	216,443	313
III	2 Centers	299,974	299,974	280
IV	2 Centers	52,754	102,754	306
V	1 Center	29,700	35,690	85
VI	3 Centers	40,088	160,354	14,767
VII	3 Centers	75,345	260,400	216
VIII	2 Centers	61,160	83,146	426
FPHSA	None	0	0	0
JPHSA	1 Center	0	12,846	88
Totals:	**19 Programs**	**$834,478**	**$1,306,726**	**16,661**

*** NOTE: Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

Region 5 indicated that funding has not been available to reinstate the two rural resource centers that were previously operational, and another program (LCH) has been reinstated on a smaller scale with SSBG funding, limited staffing and physical space. Services provided in Region 7 include Bridges, Emotions Anonymous, Tutoring, Morning Inspiration, Art Therapy, Physical Fitness/ Tai Chi, and Game Days. FPHSA has a contract with the Mental Health Association of St. Tammany to provide a psychosocial club for adults with SMI. It has helped consumers maintain placement in the community and provided respite for families. The program includes education and support groups, recreational and creative activities four days per week, five hours per day.

All consumer focused services relate to Goal 2 of the *President's New Freedom Commission Report* calling for Mental Health care that is consumer and family driven. Renewed emphasis on consumer focused services is especially needed in light of the disasters that struck Louisiana in 2005 resulting in a limited capacity to support consumer-based services.

OTHER ACTIVITIES LEADING TO REDUCTION OF HOSPITALIZATION
FY 2009 - ADULT PLAN

Utilization of state hospital beds dropped significantly with the introduction of community-based Mental Health Rehabilitation (MHR) services and the development of brief stay psychiatric acute units within general public hospitals. Moreover, Louisiana and OMH have a network of services that provide alternatives to hospitalization for consumers and families in Louisiana through a broad array of community support services and consumer-run alternatives. Housing, employment, educational, rehabilitation, and support services programs, which take into account a recovery-based philosophy of care, all contribute to reductions in hospitalization.

In the event of crisis, access to hospitalization is controlled through the Single Point of Entry (SPOE) process which assures community alternatives are tried and/or ruled out prior to inpatient hospitalization in a state inpatient facility. Implementation of the statewide Continuity of Care policy continues to enhance joint hospital-community collaboration with the goals of improved outcomes post-discharge including reduced recidivism. These tasks are inherent in Goal 5; Recommendation 4 of the *President's New Freedom Commission Report* which calls for states and communities to address the problems of acute and long term care; specifically addressing "assessing existing capacities and shortages coupled with delivering appropriate acute care services".

Another avenue of care that has reduced hospitalization rates is the revision of the Mental Health Rehabilitation program which has allowed greater flexibility of services and the ability to cover additional services such as ACT and MST, which are consumer driven and recovery-focused. Each OMH Area and Region also has specific Initiatives aimed at reducing hospitalization and/or shortening hospital stays.

Many other initiatives previously discussed have either directly or indirectly had an impact on the utilization of inpatient services. For example the Louisiana Integrated Treatment Services (LITS) model for persons with Co-occurring Mental and Substance Disorders has resulted in increasing access to community services and reducing the need for hospitalization. The advent of using effective co-occurring capable services is intertwined with Goal 4; Recommendation 3 of the *President's New Freedom Commission Report* that calls for the linking of mental health and substance abuse treatment. The development of crisis services throughout the state is another example of programming that has resulted in decreased hospital utilization. The expanding use of telemedicine has also shown great promise and results.

As a result of the hurricanes of 2005, the New Orleans area lost 378 inpatient public and private psychiatric beds resulting in an initial loss of 64% of its total capacity. The private sector has reopened some beds; however, the burden for rebuilding the hospital infrastructure has been left to the state. The result of this has been a precipitous increase in the need for acute psychiatric beds across the state and a worsened crisis in the emergency rooms of hospitals in the southern part of the state, primarily in and around New Orleans. OMH is committed to increasing alternatives to hospitalization; however, in the aftermath of the hurricanes, OMH was forced to open beds as quickly as possible in as many state facilities as possible to help alleviate the shortage of beds.

To assist in diverting people from hospitalization, the state made crisis services one of the foci of federal social service block grant (SSBG) funds. With the $55 million in SSBG money received, services such as mobile crisis teams, crisis lines, assertive community treatment teams, respite services, and wrap around services for children were developed and implemented. In the state budget authorized through the legislative session of 2007, OMH received money to sustain most of the above-mentioned services and to expand upon them.

As an adjunct to current services, Mental Health Emergency Room Extension Units (M-HERE) have been established in most regions/ LGEs. M-HEREs provide a specifically designated program within hospital emergency departments for holding, evaluating, and treating a person in crisis to determine the reasons for the individual's presentation. The M-HERE provides the opportunity for rapid stabilization in a safe, quiet environment, increasing the person's ability to recognize and deal with the situations that may instigate the crisis while working to increase and improve the network of community and natural supports. All patients receive a medical screening exam and appropriate medical evaluation.

M-HERE services include crisis stabilization and intervention; crisis risk assessment; nursing assessments; extended psychiatric observation and evaluation; behavioral health co-occurring evaluations; emergency medication; crisis support and counseling; information, liaison, advocacy consultation, and linkage to other crisis and community services. The M-HERE has the capacity to provide close supervision, observation and interaction with the patients. Unit staff can make involuntary commitment decisions. The mix and frequency of services is based on each individual's crisis assessment and treatment needs.

The M-HERE includes:

- 24/7 on site nursing coverage
- Psychiatric physician on call availability
- Social Work coverage necessary to assessment and development of discharge plans
- Security services
- Close patient observation and supervision

Discharge from the M-HERE is to one of the following: (1) an acute inpatient unit, (2) a detox unit or co-occurring unit, (3) other community based crisis services (i.e., respite), or (4) other community resources if continued crisis services are not indicated. The goal is to have at least one M-HERE in each Region/ LGE. In addition, each Region/ LGE ideally has at least one mobile crisis team, and adult and child crisis respite. The status of this initiative is as follows, with M-HEREs in most Regions/LGEs.

MHSD: University Hospital
CAHSD: Earl K Long Hospital (pending)
Region 3: Chabert Hospital
Region 4: University Medical Center
Region 5: Memorial Hospital
Region 6: Huey P. Long Hospital
Region 7: none
FPHSA: none
JPHSA: West Jefferson Hospital (pending)

CRITERION 2
MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY – INCIDENCE & PREVALENCE ESTIMATES
LOUISIANA FY 2008 ADULT PLAN

OMH has made great strides over the past decade in establishing systems to meet the growing and changing needs for information in support of management, program operations, quality improvement, and accountability. Goal #6 of the *President's New Freedom Commission Report*: "Technology Is Used to Access Mental Health Care and Information" is directly related to all aspects of Criterion 2.

OMH currently operates statewide computerized information systems covering the major service delivery and administrative programs. These systems provide a wide array of data: client characteristics, clinical assessments, type and amount of services provided, and outcome of services.

OMH-IIS is the leading-edge of OMH contemporary web-based information system development, operating in an integrated fashion over the DHH wide-area network (WAN) on a central SQL server. It is envisioned to be comprehensive in scope, and the current system has undergone phase 2 of a series of planned, sequenced enhancements. To the currently existing central client registry/continuity of care tracking sub-system and a central provider sub-system of OMH-IIS phase 1, the previously separate SPOE-MIS legacy database (see description below) and a module that allows direct data entry from the OMH standardized outcome measurement instrument, the Psychosocial Outcomes Monitoring Scales (POMS) has been added. This OMH-IIS phase 2 enhancement rolled out July 1, 2005. In July 2006, Phase 3 enhancements included transferring the functions of a legacy data system, CMHC-MIS, into OMHIIS and bringing down CMHC-MIS. This is a mainframe-based system for all 43 community mental health centers (CMHCs) statewide that has been in operation since 1981. It provides for management reporting and electronic billing of Medicaid services. Also as part of Phase 3 enhancements, ARAMIS, the Accounts Receivables and Management Information System, implemented in 1993, became the main portal for data previously entered into CMHC-MIS. ARAMIS emulates the CMHC-MIS management reporting functions for local mental health center programs and also provides for automated accounts receivable functions. It operates on a LAN. ARAMIS is a DOS-based system. Data from ARAMIS is now uploaded to OMH-IIS in ever decreasing time frames until real-time data transfer is achieved. ARAMIS itself is scheduled to be rolled into OMH-IIS as part of Phase 4 of OMH-IIS evolution, targeted for completion by the fall of 2007. The plan for further development of OMH-IIS is to sequentially replace the remaining separate, non-integrated LAN-based legacy systems now operating statewide by extending the functionality of the expanding OMH-IIS system. It also involves adding the following functions to the existing OMH-IIS system: Service event scheduling (in conjunction with service event recording); Provider credentialing & privileging (in conjunction with the current central provider registration); Expanded assessments and quality management functions, including capacity for contemporary performance & outcome measures and a continuity-of-care record; Tracking clients enrolled in evidenced-based treatments; and a central program registration system. While the current OMH-IIS employs current information technologies, rapidly changing technology and the development of standards requires its updating to serve as the core for the new system development.

OMH operates the following legacy systems. These systems are largely custom-built, LAN-based, and compliant with national data standards (e.g., Mental Health Statistics Improvement Program - MHSIP). These systems include:

PIP/PIF/ORYX. The Patient Information Program, implemented in 1992, operates in each of the five state hospitals and seven regional acute units. It provides a comprehensive array of data on inpatients served. A financial module (PIF), implemented in 1994, supports billing, and the ORYX module, implemented in 1999, supports performance reporting for JCAHO accreditation. PIP is a DOS-based system. This system is in line after ARAMIS to be rolled into OMH-IIS.

MHR/MHS & UTOPiA. The Mental Health Rehabilitation/Mental Health Services system, implemented in 1995, supports client, assessment, and service data collection and reporting for mental health rehabilitation provider agencies and contract mental health service program providers (mainly case management). The Utilization, Tracking, Oversight, and Prior Authorization system provides for prior authorization of services and utilization and outcomes management at the state and area levels. MHR/MHS & UTOPiA run in Visual Fox Pro. There is recent interest in evaluating the possibility of incorporating the functions of MHR/MHS & UTOPiA into OMHIIS during Phase 4 enhancements.

In addition to the above custom-built systems, OMH also operates proprietary Health Care Systems (HCS) Medics pharmacy software in each of the seven regional community pharmacies and each of the five state hospitals. This software automates prescription processing and management reporting of utilization of pharmaceuticals. It interfaces with PIP in the hospitals to capture patient admission data.

In addition to the above listed OMH data systems, there exist program specific data systems that are supported by OMH. These include the data system for the Child and Adolescent Response Team (CART), Early Childhood Supports and Services (ECSS), and the Louisiana Youth Enhancement Services (LA-YES). In each case, these specialized service programs have unique database needs that have been addressed by either building a suitable database in-house or in the case of LA-YES, purchasing a compatible commercial data management system. In each of these cases, efforts have been made to make sure that whatever system is being used, its structure and data formats are compatible with OMH-IIS such that key clinical information can be uploaded to OMH-IIS which is the primary repository of this information for OMH.

According to the *2007 Annual Estimates of the Resident Population by Single Year – 7/1/2007 State Characteristics, Population Estimates Division, U.S. Census Bureau (released May 1, 2008)*, the total number of adults in Louisiana is 3,213,644. Of these, according to national benchmarks, 2.6% are expected to have Serious Mental Illness (SMI). That translates into a total of 83,555 adults with serious mental illness (SMI) in Louisiana based on national prevalence rates.

Statistics show that 34,664 adults with SMI received outpatient services under the OMH umbrella in FY 2008 through both Community Mental Health Centers and the Mental Health Rehabilitation (MHR) program. It is noted that this is consistent with the numbers served in 2007, although a strict comparison is not feasible since this is the first year that Jefferson Parish Human Services Authority (JPHSA) has supplied their statistics for inclusion. The Mental Health Rehab (MHR) program served 1,459 adults. Of the total number of adults served, both with and without SMI (41,509), 84% met the definition of Seriously Mentally Ill (SMI). As has been true since the hurricanes, many individuals

who were in acute crises were seen in CMHCs as a result of the aftermath of the hurricanes, and did not meet the more strict criteria of SMI.

As the term is used in Louisiana, SMI is a national designation that includes only those individuals suffering from the most severe forms of mental illness. Those who have any type of mental illness would increase the population figures, but not the numbers of individuals served, since Louisiana's outpatient mental health facilities are designated to serve only those individuals with SMI. Therefore, individuals with SMI are considered to be the target population for these programs. These numbers reflect an unduplicated count within regions and LGEs.

ADULTS – CMHC PERSONS SERVED
UNDUPLICATED WITHIN REGIONS/ LGEs FY 07-08

Regions / LGEs / Mental Health Rehab	Adults with SMI Served (persons served)	Total Adults Served	% SMI
3,4,5,6,7, & 8	16,307	19,269	85%
MHSD	5,376	7,542	71%
CAHSD	5,094	6,272	81%
FPHSA	3,104	3,451	90%
JPHSA	3,324	3,516	95%
MHR	1,459	1,459	100%
Totals	**34,664**	**41,509**	**84%**

NOTE: FY 2007-08 is the first year that JPHSA has submitted these numbers

Data Definitions & Methodology

SMI and EBD Definitions: OMH population definitions follow the national definition.

Estimation Methodology: OMH uses the CMHS estimation methodology, applying the national prevalence rates for SMI (2.6%) and EBD (9%) directly to current general population counts to arrive at the estimated prevalence of targeted persons to be served. This method has been used since the revised rates were published in 1996.

Sub-populations: This information is not available, since the only prevalence estimate available is the gross number of targeted persons in the population. There have been no local epidemiological studies or needs assessment that would result in information this specific.

Dual Diagnosis: Please refer to Block Grant Uniform Reporting Tables to be included with the Implementation Report for this information.

Access: See the Gaps section of the Context Section of this report for this information. The largest groups of persons not having sufficient access are children/youth and families, as indicated by the discrepancy between prevalence and number served each year.

Adult Target Population

An adult who has a serious and persistent mental illness meets the following criteria for *Age, Diagnosis, Disability*, and *Duration.*

Age: 18 years of age or older

Diagnosis: Severe non-organic mental illnesses including, but not limited to schizophrenia, schizo-affective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships and work or school.

Disability: Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:

1. Unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.
2. Employed in a sheltered setting.
3. Requires public financial assistance for out-of-hospital maintenance (i.e., SSI) and/or is unable to procure such without help; does not apply to regular retirement benefits.
4. Severely lacks social support systems in the natural environment (i.e., no close friends or group affiliations, lives alone, or is highly transient).
5. Requires assistance in basic life skills (i.e., must be reminded to take medicine, must have transportation arranged for him/her, needs assistance in household management tasks).
6. Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

Duration: Must meet at least one of the following indicators of duration:

1. Psychiatric hospitalizations of at least six months in the last five years (cumulative total).
2. Two or more hospitalizations for mental disorders in the last 12 month period.
3. A single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months.
4. A previous psychiatric evaluation or psychiatric documentation of treatment indicating a history of severe psychiatric disability of at least six months duration.

OMH is in the process of revising and refining the definition of the Target Population to include such things as clients' functional status.

Louisiana Post- Hurricane Prevalence Estimates

Over the last three years, Louisiana population figures have been extremely difficult to estimate based on the mass evacuations following Hurricanes Katrina and Rita. Overall, the population of the State is smaller than prior to the storms due to mass evacuations to other states in the days and weeks after the hurricanes. While many evacuees have returned to the state, and others are expected to return, the population figures continue to be in flux, making estimates difficult, and somewhat unreliable. Within the state, the parishes hardest hit by the hurricanes experienced an overall decrease in population, while some other parishes experienced an increase in population. The *2005 American Community Survey Gulf Coast Area Data Profiles: September through December, 2005 (revised July 19, 2006)* were released in an attempt to measure the population post – hurricanes, and at that time there were estimated to be 3,688,996 individuals in Louisiana, with 2,742,070 adults, and 945,926 children. The Population Division of the US Census Bureau recently published the *Annual Estimates of the Resident Population by Single-Year 7/1/2007 - State Characteristics Population Estimates* (Released May 1, 2008). The more recent data is listed in the tables below. A comparison of these sets of figures shows that the trend is for Louisiana's population to once again increase.

In addition, estimates of the prevalence of mental illness within the state, parishes, regions, and LGEs for Adults and Children/ youth are shown in the following tables. Caution should be used when utilizing these figures, as there is much population movement and the figures may not be entirely reliable.

PREVALENCE ESTIMATES*

July 1, 2007 (Released May 1, 2008)

	Child/ Youth 9%		Adult 2.6%		Total	
Louisiana	Pop Count	Prev Count	Pop Count	Prev Count	Pop Count	Prev Count
State-wide	1,079,560	97,160	3,213,644	83,555	4,293,204	180,715

*Based on Annual Estimates of the Resident Population by Single-Year 7/1/2007 State Characteristics Population Estimates Population Division, U.S. Census Bureau. (Released May 1, 2008)

Prev. Count = Estimated Prevalence Count (2.6% Adults*, 9%Children**) Adult =18 Years of Age and Older
Child/Youth =17 Years of Age and Younger
* Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.
** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.

Please note: Louisiana uses the designation SMI for what is more usually referred to as SPMI.
SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness. Those who have all types of mental illness would increase the population figures, but would not increase the numbers of individuals served since Louisiana's facilities are designated to serve those with SMI (SPMI).

Estimated State Population and Estimated Prevalence of Adults with Serious Mental Illness and Child/Youth with Emotional Behavioral Disorders by Region/District and Parish (July 1, 2007 Pop Est)*

Region/ District	PARISH	CHILD/ YOUTH (Age 0-17) POP. EST.	CHILD/ YOUTH (Age 0-17) PREV. EST.	ADULT (Age 18 and up) POP. EST.	ADULT (Age 18 and up) PREV. EST.	TOTAL POP. EST. JULY 1, 2007	TOTAL PREV. EST.
1-METROPOLITAN HUMAN SERVICE DISTRICT	Orleans Parish	44,085	3,968	195,039	5,071	239,124	9,039
	Plaquemines Parish	5,652	509	15,888	413	21,540	922
	St. Bernard Parish	3,382	304	16,444	428	19,826	732
Total for 1-MHSD		53,119	4,781	227,371	5,912	280,490	10,692
2-CAPITAL AREA HUMAN SERVICE DISTRICT	Ascension Parish	28,684	2,582	70,372	1,830	99,056	4,411
	East Baton Rouge Parish	107,470	9,672	322,847	8,394	430,317	18,066
	East Feliciana Parish	4,726	425	16,107	419	20,833	844
	Iberville Parish	7,767	699	24,734	643	32,501	1,342
	Pointe Coupee Parish	5,412	487	16,980	441	22,392	929
	West Baton Rouge Parish	5,778	520	16,847	438	22,625	958
	West Feliciana Parish	2,454	221	12,659	329	15,113	550
Total for 2-CAHSD		162,291	14,606	480,546	12,494	642,837	27,100
Region 3	Assumption Parish	5,628	507	17,363	451	22,991	958
	Lafourche Parish	22,659	2,039	70,054	1,821	92,713	3,861
	St. Charles Parish	13,862	1,248	38,182	993	52,044	2,240
	St. James Parish	5,602	504	15,976	415	21,578	920
	St. John the Baptist Parish	13,739	1,237	33,945	883	47,684	2,119
	St. Mary Parish	13,553	1,220	37,758	982	51,311	2,201
	Terrebonne Parish	28,901	2,601	79,523	2,068	108,424	4,669
Total for Region 3		103,944	9,355	292,801	7,613	396,745	16,968
Region 4	Acadia Parish	16,639	1,498	43,319	1,126	59,958	2,624
	Evangeline Parish	9,803	882	26,102	679	35,905	1,561
	Iberia Parish	20,621	1,856	54,344	1,413	74,965	3,269
	Lafayette Parish	52,804	4,752	152,039	3,953	204,843	8,705
	St. Landry Parish	24,782	2,230	66,580	1,731	91,362	3,961
	St. Martin Parish	13,726	1,235	37,925	986	51,651	2,221
	Vermilion Parish	14,293	1,286	41,398	1,076	55,691	2,363
Total for Region 4		152,668	13,740	421,707	10,964	574,375	24,705

Estimated State Population and Estimated Prevalence of Adults with Serious Mental Illness and Child/Youth with Emotional Behavioral Disorders by Region/District and Parish (July 1, 2007 Pop Est)*

Region/ District	PARISH	CHILD/ YOUTH (Age 0-17) POP. EST.	CHILD/ YOUTH (Age 0-17) PREV. EST.	ADULT (Age 18 and up) POP. EST.	ADULT (Age 18 and up) PREV. EST.	TOTAL POP. EST. JULY 1, 2007	TOTAL PREV. EST.
Region 5	Allen Parish	**5,902**	531	**19,622**	510	**25,524**	1,041
	Beauregard Parish	**8,865**	798	**25,911**	674	**34,776**	1,472
	Calcasieu Parish	**47,291**	4,256	**137,221**	3,568	**184,512**	7,824
	Cameron Parish	**1,553**	140	**5,861**	152	**7,414**	292
	Jefferson Davis Parish	**8,407**	757	**22,770**	592	**31,177**	1,349
Total for Region 5		**72,018**	6,482	**211,385**	5,496	**283,403**	11,978
Region 6	Avoyelles Parish	**10,691**	962	**31,478**	818	**42,169**	1,781
	Catahoula Parish	**2,458**	221	**7,994**	208	**10,452**	429
	Concordia Parish	**4,762**	429	**14,296**	372	**19,058**	800
	Grant Parish	**5,124**	461	**14,634**	380	**19,758**	842
	La Salle Parish	**3,389**	305	**10,652**	277	**14,041**	582
	Rapides Parish	**33,485**	3,014	**96,594**	2,511	**130,079**	5,525
	Vernon Parish	**14,758**	1,328	**32,622**	848	**47,380**	2,176
	Winn Parish	**3,421**	308	**12,100**	315	**15,521**	622
Total for Region 6		**78,088**	7,028	**220,370**	5,730	**298,458**	12,758
Region 7	Bienville Parish	**3,574**	322	**11,333**	295	**14,907**	616
	Bossier Parish	**29,582**	2,662	**79,123**	2,057	**108,705**	4,720
	Caddo Parish	**64,165**	5,775	**188,444**	4,900	**252,609**	10,674
	Claiborne Parish	**3,445**	310	**12,838**	334	**16,283**	644
	De Soto Parish	**6,716**	604	**19,553**	508	**26,269**	1,113
	Natchitoches Parish	**9,734**	876	**29,751**	774	**39,485**	1,650
	Red River Parish	**2,520**	227	**6,675**	174	**9,195**	400
	Sabine Parish	**5,835**	525	**17,848**	464	**23,683**	989
	Webster Parish	**9,554**	860	**31,370**	816	**40,924**	1,675
Total for Region 7		**135,125**	12,161	**396,935**	10,320	**532,060**	22,482

Estimated State Population and Estimated Prevalence of Adults with Serious Mental Illness and Child/Youth with Emotional Behavioral Disorders by Region/District and Parish (July 1, 2007 Pop Est)*

Region/ District	PARISH	CHILD/ YOUTH (Age 0-17) POP. EST.	CHILD/ YOUTH (Age 0-17) PREV. EST.	ADULT (Age 18 and up) POP. EST.	ADULT (Age 18 and up) PREV. EST.	TOTAL POP. EST. JULY 1, 2007	TOTAL PREV. EST.
Region 8	Caldwell Parish	**2,353**	212	**7,954**	207	**10,307**	419
	East Carroll Parish	**2,247**	202	**6,055**	157	**8,302**	360
	Franklin Parish	**5,093**	458	**14,967**	389	**20,060**	848
	Jackson Parish	**3,517**	317	**11,622**	302	**15,139**	619
	Lincoln Parish	**9,057**	815	**33,505**	871	**42,562**	1,686
	Madison Parish	**3,431**	309	**8,427**	219	**11,858**	528
	Morehouse Parish	**7,155**	644	**21,628**	562	**28,783**	1,206
	Ouachita Parish	**39,595**	3,564	**109,907**	2,858	**149,502**	6,421
	Richland Parish	**5,202**	468	**15,267**	397	**20,469**	865
	Tensas Parish	**1,365**	123	**4,500**	117	**5,865**	240
	Union Parish	**5,527**	497	**17,246**	448	**22,773**	946
	West Carroll Parish	**2,594**	233	**8,959**	233	**11,553**	466
Total for Region 8		**87,136**	7,842	**260,037**	6,761	**347,173**	14,603
9-FLORIDA PARISHES HUMAN SERVICE AREA	Livingston Parish	**31,723**	2,855	**84,857**	2,206	**116,580**	5,061
	St. Helena Parish	**2,612**	235	**8,008**	208	**10,620**	443
	St. Tammany Parish	**58,962**	5,307	**167,663**	4,359	**226,625**	9,666
	Tangipahoa Parish	**30,410**	2,737	**84,988**	2,210	**115,398**	4,947
	Washington Parish	**11,558**	1,040	**33,362**	867	**44,920**	1,908
Total for 9-FPHSA		**135,265**	12,174	**378,878**	9,851	**514,143**	22,025
10-JEFFERSON PARISH HUMAN SERVICE AREA	Jefferson Parish	**99,906**	8,992	**323,614**	8,414	**423,520**	17,406
STATE TOTAL		**1,079,560**	97,160	**3,213,644**	83,555	**4,293,204**	180,715

SC-EST2007-alldata5: Annual State Population Estimates by Demographic
File: 7/1/2007 County Characteristics Resident Population Estimates File for Internet Display
Source: Population Division, U.S. Census Bureau
Release Date: May 1, 2008

http://www.census.gov/popest/datasets.html

Prev. Count = Estimated Prevalence Count (2.6% Adults*, 9%Children**)

Adult =18 Years of Age and Older -- Child/Youth =17 Years of Age and Younger

** Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.*

*** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.*

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POPULATION, PERCENTAGES & CASELOAD BY AGE
FY 2009 - ADULT PLAN

State's Population By Age Range*		
Age Range	**Number of Persons**	**Percentage of State's Population**
0-17	1,079,560	25%
18+	3,213,644	75%
TOTAL	4,293,204	100%

*Based on Annual Estimates of the Resident Population by Single-Year 7/1/2007 State Characteristics Population Estimates Population Division, U.S. Census Bureau. (Released May 1, 2008)

CMHC ADULT CASELOAD SIZE ON LAST DAY OF FY2007 & FY2008

	FY06-07			FY07-08		
	Age 18-64	**Age 65+**	**TOTAL 18+**	**Age 18-64**	**Age 65+**	**TOTAL 18+**
REGION						
1-MHSD	5024	213	5237	7047	298	7345
2-CAHSD	4367	262	4629	4543	269	4812
3	4167	275	4442	4614	286	4900
4	3240	166	3406	3505	166	3671
5	888	35	923	966	35	1001
6	1704	74	1778	1955	84	2039
7	1745	93	1838	1571	80	1651
8	1659	96	1755	1795	89	1884
9-FPHSA	2281	132	2413	2454	136	2590
10-JPHSA	2110	93	2203	2526	94	2620
TOTAL	27185	1439	28624	30976	1537	32513

Data from CMHC ARAMIS and JPHSA

CASELOAD WITH SMI/EBD ON LAST DAY OF FISCAL YEAR 2008

CASELOAD ON June 30, 2008 CMHC/PIP	ADULT: SMI CHILD: SED		OTHER		
	COUNT	**Percent**	**COUNT**	**Percent**	**TOTAL**
Age 0-17	4,286	77	1,308	23	5,594
Age 18+	27,619	82	5,993	18	33,612
.	2	8	23	92	25
TOTAL	31,907	81	7,324	19	39,231

Data from CMHC ARAMIS, PIP and JPHSA

NOTE: Totals from previous years reporting in the Block Grant have not included data from Jefferson Parish Human Service Authority (not available)

PERSONS SERVED BY OMH COMPARED TO PREVALENCE ESTIMATES AND CENSUS DATA FY 2009 - ADULT PLAN

Age Range	LA Population Estimated*	National Prevalence Rate	Est. Number of persons in LA Population with SMI/EBD
Child/ Youth* 0-17	1,079,560	9%	1,079,560 X .09= **97,160**
Adult 18+**	3,213,644	2.6%	3,213,644 X .026= **83,555**
Total	4,293,204	-----	**180,715**

*Based on Annual Estimates of the Resident Population by Single-Year 7/1/2007 State Characteristics Population Estimates Population Division, U.S. Census Bureau. (Released May 1, 2008)

Age Range	Est. Number of persons in LA population with SMI/EBD	Number of Persons with SMI/EBD in OMH Caseload	Louisiana Percent of Prevalence Served
Child/ Youth 0-17	97,160	4,286	4,286 / 97,160= **4.4 %**
Adult 18+	83,555	27,619	27,619 / 83,555= **33 %**
Total	180,715	31,905	31,905 / 180,715= **18 %**

Prev. Count = Estimated Prevalence Count (2.6% Adults*, 9%Children**) Adult =18 Years of Age and Older
Child/Youth =17 Years of Age and Younger
* Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.
** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.

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CRITERION 2
MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY – QUANTITATIVE TARGETS

Setting quantitative goals to be achieved for the numbers of adults who are seriously mentally ill to be served in the public mental health system is a key requirement of the mental health block grant law, and relates directly to the *President's New Freedom Commission Report*, Goal # 4, Early Mental Health Screening, Assessment, & Referral to Services Are Common Practice.

The Office of Mental Health has set a goal to increase access to mental health services to persons with SMI/ EBD. Quantitatively, this means increasing the numbers of new admissions of persons with SMI/ EBD. Quantitative targets relate to the National Outcome Measure (NOMS) Performance Indicator "Increased Access to Services". Louisiana reported this indicator in the past as the percentage of prevalence of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. The measure of the NOMS is now being requested to be reported as simply the number of persons who have a mental illness and receive services.

Previously, the measure was reported as a percentage:

- Numerator: Estimated unduplicated count of adults who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting.
- Denominator: Estimated prevalence of adults in Louisiana with serious mental illness during a twelve month period.

These figures for the preceding years were:

FY 2004 23,954/ 84,475 X 100 = 28.36%
FY 2005 25,297/ 84,475 X 100 = 29.95%
FY 2006 25,301/ 71,294 X 100 = 35.49% (see below)
FY 2007 27,619/ 83,555 X 100 = 33.05 %

Due to the hurricanes, the population figures may be invalid. Since the population of the state has decreased, and efforts to reach the SMI population have intensified, *the percent of prevalence for the FY 2006 may have been falsely inflated*. Perhaps more than any other criteria, the Indicators for Criterion #2 continue to be the most difficult to predict or plan for. Post-hurricanes, there is simply no baseline upon which to estimate the outcomes for this Criterion.

- For specific information on the quantitative targets that are now reported only as the unduplicated count of adults (i.e., the Numerator only) who have serious mental illness and who receive mental health services during the fiscal year (7/1-6/30) in an OMH community or inpatient setting see the Performance Indicator section of this document.

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS – OUTREACH TO HOMELESS
LOUISIANA FY 2009 - ADULT PLAN

Even three years out, no discussion of homelessness in Louisiana can be undertaken without an acknowledgement of the devastation caused by Hurricanes Katrina and Rita. There is no doubt that the disasters continue to have a tremendous impact on housing and homelessness in the state. This is particularly significant since the areas of the state that were the most directly hit by the storms were the areas that traditionally have the greatest population, and therefore the highest rates of homelessness, as well as the highest numbers of people with mental illness. State housing recovery efforts for affordable housing continue amidst a multiplicity of barriers including changes in development costs at all levels and local resistance to affordable housing development.

Clients Reporting Being Homeless as of 6/30/2008 Compared to 6/30/2007

Region/ LGE	Total number reporting homelessness as of **6/30/07**	Total number reporting homelessness as of **6/30/08**	Of total number, how many were displaced by hurricanes/ disaster **(6/30/2007)**	Of total number, how many were displaced by hurricanes/ disaster **(6/30/2008)**	Methodology used to arrive at these figures**
MHSD*	2250 (6/30/06)	2219 (6/30/07)	2150 (6/30/06)	1745 (6/30/07)	Point in time survey
CAHSD	1100	1077	320	320	Point in time survey
Region III	788	677	169	128	Point in time survey, HMIS Data
Region IV	172	172	unk	unk	Point in time survey
Region V	204	204	unk	unk	Point in time survey
Region VI	233+ unk	456	41+unk	32	Not indicated
Region VII	1615	1143	279	0	Point in time survey
Region VIII	451	286	315	n/a	Point in time survey
FPHSA	434	683	224	Unk	Point in time survey
JPHSA	480	481	280	432	HMIS Data

NOTES:

*** Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

****HMIS: Homeless Management Information System Data**

It is noted that HUD does not consider people who are in shelters, supportive housing and FEMA housing as "homeless" and therefore numbers that include people who are *displaced from their homes* are not technically 'homeless' and these numbers are actually much greater than reflected in this table. For example, in the 2007 Point in Time Survey, FPHSA indicated that a total of 1407 persons stated that they were *displaced* by Hurricanes Katrina and Rita, in comparison to 224 in the table above.

The State Department of Social Services is responsible for the state's Emergency Shelter Grant funds. As part of the Department's grantee responsibilities, the department surveys shelters and compiles an annual report on the unduplicated numbers served in shelters across the state. The Louisiana

Interagency Action Council on Homelessness, member of the United States Interagency Council on Homelessness, publishes a biannual report using these figures as well as figures reported by the regional Continuums of Care. Used together these reports are significant because they capture an unduplicated annual count of the number of homeless served and because they capture the number of persons with co-occurring mental illness and addictive disorders. The shelter survey information is current through 2006. In the annual shelter report, the yearly total of homeless served is 37,154 people. The DSS Shelter Survey for 2007 reported 31,946 unduplicated total homeless people. New Orleans did not participate in the 2007 Shelter Survey. They are reporting an approximate 12,000 homeless people in New Orleans (as per *Unity for the Homeless*). Therefore, including New Orleans the total number is closer to 43,946.

The Projects to Assist in Transition from Homelessness (PATH) program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. Louisiana's PATH program provides a significant amount of *outreach* activity as well as other support services. An unduplicated count of services provided by state PATH providers for 2006-2007 is included in our consideration of the number of homeless people with mental illness. In the annual PATH report, Louisiana's PATH providers report having served an unduplicated number of 4,977 persons who were literally homeless and have mental illness. Because prevalence rates indicate that 25-30% of those sheltered homeless suffer from serious mental illness and because experience suggests that persons with mental illness are underserved in the general shelter population and who are therefore not being counted in shelter surveys, it is reasonable to use the 30% figure when estimating number of homeless with mental illness.

Taking those factors into consideration, an estimate of the number of persons with mental illness, inclusive of those with co-occurring addictive disorders, who are homeless is approximately 13,184 persons, or 30% of the total homeless population as reported in the annual shelter survey.

One of the greatest needs in Louisiana is the creation of housing that is affordable to persons living on an income level that is comparable to that of SSI recipients. That is, housing that is aimed at those individuals at and below 20% of Median Income. Supportive services necessary to assist an individual in remaining housed are also crucial. Efforts to increase available and appropriate housing for persons with mental illness through training and recruitment of housing providers and developers and development and access to support services continues to be a priority.

There are multiple providers of homeless programs in each area of the state. Each Region / LGE has a Continuum of Care for the Homeless that serves as the coordinating body for the development of housing and services to the homeless. The regional Continuums of Care incorporates a complete array of assistance for homeless clients from outreach services to placement in permanent housing. Both private and public agencies are members of these organizations. The programs provide outreach and/or shelter and housing services to the homeless, as well as substance abuse and mental health services. Services targeted to the elderly, children, youth and their families who are homeless have been generally limited in the past, however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state.

For the federal PATH funding, Louisiana relies on in-kind contributions as its federal match. For FY 08 the match amount is $343,000. Virtually all of the PATH service providers are part of the local Continuum of Care systems for the homeless. As a part of the planning process, these coalitions

participate and facilitate public hearings to request comment on the current use of funding in support of homelessness, and provide opportunities of public comment.

The Louisiana Road Home Recovery Plan, an initiative of the Louisiana Recovery Authority (LRA) has included the rebuilding of affordable housing in the areas most impacted by Hurricanes Katrina and Rita. This is to be accomplished through a system of housing development funding incentives that encourage the creation of mixed income housing developments. This plan targets not only the metropolitan areas impacted by the hurricanes but also several of the rural parishes that were more impacted by hurricane Rita. Included in this plan is the use of Permanent Supportive Housing as a model for housing and supports for people with special needs, such as people with disabilities, older people with support needs, families with children/youth who have disabilities and youth aging out of foster care. It is a model that provides for housing that is fully integrated into the community through setting aside, within each housing development built, a percentage of housing units for persons in special population categories and includes support services that are delivered in the individual's (or family's) home. Adults with SMI and families of children with emotional/behavioral disorders, and the frail elderly are included within the identified special needs population targeted for the supportive housing set aside units. The services to be delivered to persons/families in the target population will be those services likely to help them maintain housing stability.

In a 2007 survey of CAHSD consumers it was found that of those who were homeless, 34% stated that they were homeless due to addictions, 25% due to mental health problems, and 23% due to Katrina. Various programs are operational to address difficulties reaching the homeless population. For example, Region 8 has contracted with Volunteers of America to engage in a Homeless Outreach program designed to re-engage local homeless individuals in treatment.

Programs that aid persons with mental illness who are homeless relate to eliminating the disparities in mental health services, Goal #3 of the *President's New Freedom Commission Report*.

For further discussion aspects of homelessness, the reader is referred to *Section III, Criterion 1, Housing Services.*

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS – RURAL ACCESS TO SERVICES
LOUISIANA FY 2008 - ADULT PLAN

A *Rural Area* has been defined by OMH using the 1990 U.S. Bureau of the Census definition: A rural area is one in which there is no city in the parish (county) with a population exceeding 50,000. Louisiana is a largely rural state, with 88% (56) of its 64 parishes considered rural by this definition. There is an OMH mental health center or satellite clinic in 45 of these 56 rural parishes. There is a Mental Health Rehabilitation provider located in most of the rural parishes.

Although OMH has placed many new programs in rural areas, barriers, especially transportation, continue to restrict the access of consumers to these rural mental health programs. Transportation in the rural areas of the state has long been problematic, not only for OMH consumers, but for the general public living in many of these areas. The lack of transportation resources not only limits access to mental health services, but to employment and educational opportunities. The resulting increased social isolation of many OMH clients with serious mental illness who live in these areas is a primary problem and focus of attention for OMH. Efforts to expand the number of both mental health programs and recruiting of transportation providers in rural areas are an ongoing goal.

RURAL TRANSPORTATION PROGRAMS FOR SMI / EBD 2007-2008

Region/ LGE	Type of Programs	# of Rural Programs
MHSD*	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	3
CAHSD	Medicaid Transportation, City/Parish Transportation; Local Providers, Other	32
III	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	9
IV	Medicaid Transportation, City/Parish Transportation, Local Providers	11
V	Medicaid Transportation; City/Parish Transportation; Local Providers, Other	16
VI	Medicaid Transportation, City/Parish, Local Providers, Others	10
VII	Medicaid Transportation, City/Parish, Local Providers, Other	21
VIII	Medicaid Transportation, City/Parish	5
FPHSA	Medicaid Transportation, City/Parish, Local Providers, Other	19
JPHSA	*NO RURAL AREAS	0
TOTAL		**126**

*** NOTE: Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

RURAL MENTAL HEALTH PROGRAMS FOR SMI / EBD 2007-2008

Region/ LGE	Name/Type of Programs	# of Adult Rural Programs	# of C/Y Rural Programs
MHSD*	CMHC, Outreach Sites, Other	2	6
CAHSD	CMHC, Satellite Clinics, Outreach Sites, ACT teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	19	19
III	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups	8	10
IV	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	24	11
V	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, MHR Agencies, Support Groups, Other	20	13
VI	CMHC, Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR, Support Groups, Other	23	14
VII	CMHC, Outreach Sites, ACT teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups	7	4
VIII	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups	24	23
FPHSA	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	20	10
JPHSA	* NO RURAL AREAS	0	0
TOTAL		**147**	**110**

Key: CMHC= Community Mental Health Center
ACT= Assertive Community Treatment Team
MHR= Medicaid Mental Health Rehabilitation Program

*** NOTE: Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

The capacity for telemedicine, tele-networking, and teleconferencing throughout the state has resulted in better access to the provision of mental health services in rural areas. All state hospitals and approximately almost all CMHC's have direct access. This system addition is actively used for conferencing, consultation and direct care.

In an attempt to alleviate access problems, OMH has available teleconferencing systems at 51 sites, including 29 Mental Health clinics, two ECSS sites, five Mental Health Hospitals, two at LA Spirit, one at an OMH regional office, and one at OMH Central Office. All hospitals, three clinics, and OMH Central Office have multiple cameras at their sites. Some of these cameras are dedicated to Telemedicine (doctor/client session) while the others are used for Teleconferencing

(meetings, education, etc). The other sites use their single cameras for both Telemedicine and Teleconferencing. The Office of Mental Health had purchased 23 new systems to replace existing out of date systems at the clinics, some of which were damaged by the hurricanes. All of these systems were installed by September 2007. In addition to this equipment, OMH purchased an additional 18 camera/monitor systems in FY08 of which 13 are online as of June 25, 2008.

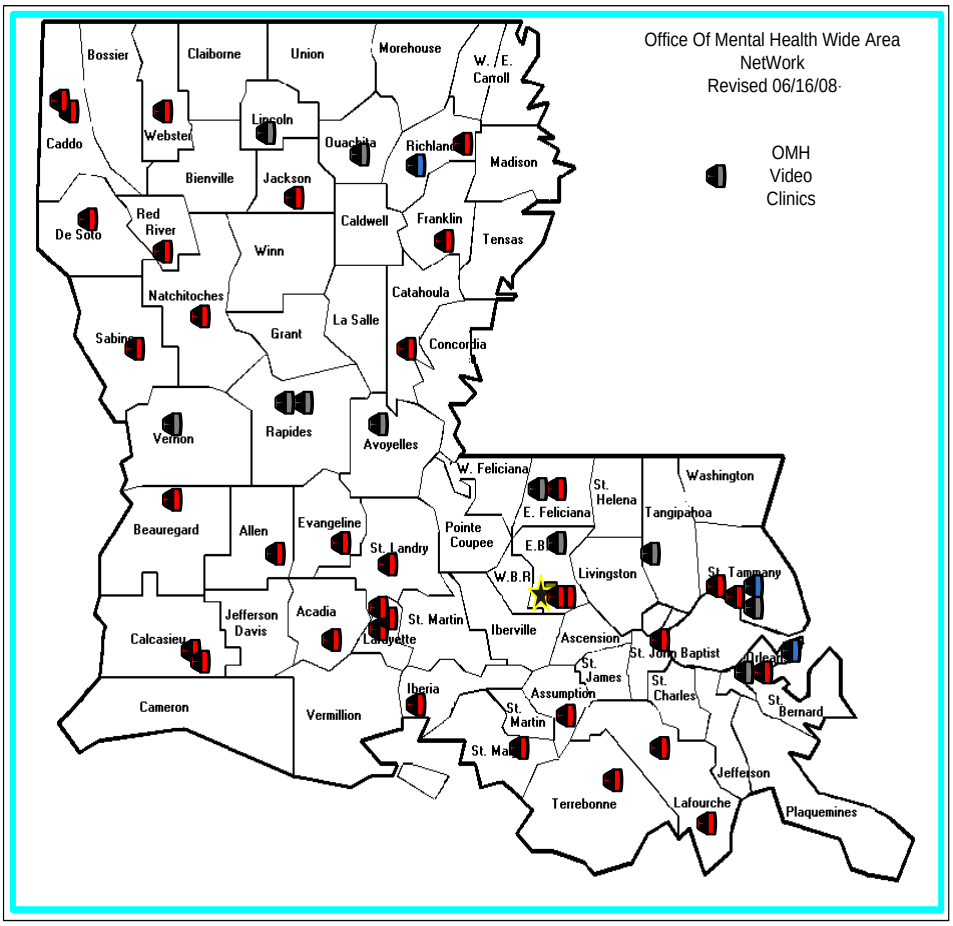
Telecommunication has become the primary mode for communication within OMH. In an average week there are 20 different meetings conducted through teleconferencing including regular meetings of the Regional and Area Management Teams, Medical Directors, Quality Council, and the Pharmacy and Therapeutics Committee. The system is also used for training and other administrative purposes. Past examples include ECSS trainings and preparations for JCAHO accreditation. The system is used every Thursday for regional managers and medical directors to address recovery and resiliency, utilization management, staff competency and credentialing, and performance improvement. Forensic patients at ELMHS are being linked with Tulane University psychiatrists in New Orleans through telemedicine. Tests have begun that will result in a linkage between Southeast Louisiana Hospital and the LSUHSC Emergency Departments. Combined, these efforts have resulted in more efficient communication between various sites across the state.

OMH Video Conferencing Sites - June, 2008

	Site	Parish	City
1	Allen Mental Health Center	Allen	Oberlin
2	Assumption Mental Health Center	Assumption	Labadieville
3	Avoyelles Mental Health Center	Avoyelles	Marksville
4	Beauregard Mental Health Center	Beauregard	DeRidder
5	CLSH (Education Room 103)	Rapides	Pineville
6	CLSH (Education Room 128)	Rapides	Pineville
7	Crowley Mental Health Center	Acadia	Crowley
8	Delta ECSS	Richland	Delhi
9	Dr. Joseph Tyler MHC / Auditorium 2	Lafayette	Lafayette
10	Dr. Joseph Tyler MHC / Auditorium 3	Lafayette	Lafayette
11	Dr. Joseph Tyler MHC / Conference Room	Lafayette	Lafayette
12	ELMHS (Center Bldg.)	East Feliciana	Jackson
13	ELMHS (Forensic)	East Feliciana	Jackson
14	ELMHS (Greenwell Springs)	East Baton Rouge	Greenwell Springs
15	Jonesboro Mental Health Center	Jackson	Jonesboro
16	Jonesville Mental Health Center	Catahoula	Jonesville
17	Lafourche Mental Health Center	Lafourche	Raceland
18	Lake Charles MHC / Room 121	Calcasieu	Lake Charles
19	Lake Charles MHC / Room 105	Calcasieu	Lake Charles
20	LA Spirit	East Baton Rouge	Baton Rouge
21	LA Spirit Orleans	New Oleans	Orleans

22	Leesville Mental Health Center	Vernon	Leesville
23	Mansfield Mental Health Center	De Soto	Mansfield
24	Many Mental Health Center	Sabine	Many
25	Minden Mental Health Center	Webster	Minden
26	Monroe Mental Health Center	Ouachita	Monroe
27	Natchitoches Mental Health Center	Natchitoches	Natchitoches
28	New Iberia Mental Health Center	Iberia	New Iberia
29	NOAH / Shrevington Conference Room	Orleans	New Orleans
30	NOAH / HR Conference Room	Orleans	New Orleans
31	OMH Headquarters	East Baton Rouge	Baton Rouge
32	Opelousas Mental Health Center	St. Landry	Opelousas
33	Region 3 Office	Terrebonne	Houma
34	Red River Mental Health	Red River	Coushatta
35	Richland Mental Health Center	Richland	Rayville
36	River Parishes Mental Health Center	St.John the Baptist	LaPlace
37	Rosenblum Mental Health Center	Tangipahoa	Hammond
38	Ruston Mental Health Center	Lincoln	Ruston
39	SELH / Admin. Bldg	St. Tammany	Mandeville
40	SELH / Education Bldg	St. Tammany	Mandeville
41	SELH / Telemed	St. Tammany	Mandeville
42	Shreveport MHC / Room 111	Caddo	Shreveport
43	Shreveport MHC / Room 145	Caddo	Shreveport
44	Shreveport MHC / System of Care	Caddo	Shreveport
45	South Lafourche MHC	Lafourche	Galliano
46	St. Mary Mental Health Center	St. Mary	Morgan City
47	St. Tammany ECSS	St. Tammany	Mandeville
48	Tallulah Mental Health Center	Madison	Tallulah
49	Terrebonne Mental Health Center	Terrebonne	Houma
50	Ville Platte Mental Health Center	Evangeline	Ville Platte
51	Winnsboro Mental Health Center	Franklin	Winnsboro

Location of OMH Video Conferencing Sites



Many regions reported that the hurricanes put a greater strain on their ability to provide services in rural areas. An increase in evacuees, a decrease in staffing, budget cuts, increased needs for medications, and more frequent emergencies have all increased the burden on existing service providers. Gasoline prices that have hit record highs have hit the rural population harder.

CAHSD established an adult mobile team with seven satellite clinic teams to serve the adult population; these services remain intact, and have greatly increased the accessibility of services to the clients in outlying areas. Region III reported that their ability to serve rural consumers was affected due to an increased population, a lack of hospital beds, longer travel times to services, increased numbers of clients in crisis, and more demand for counseling services. In addition, Region III notes that there is limited development of permanent housing. Region IV notes that new behavioral health services have been designed and implemented throughout the Region including rural areas, as a result of SSBG funds

Programs that improve services available to persons with mental illness who live in rural areas relate to eliminating the disparities in mental health services, Goal #3 of the *President's New Freedom Commission Report*.

CRITERION 4
TARGETED SERVICES TO RURAL, HOMELESS, AND OLDER ADULT POPULATIONS – SERVICES FOR OLDER ADULTS
LOUISIANA FY 2009 - ADULT PLAN

The Office of Mental Health recognizes that access and utilization of mental health care by older adults is an important statewide area of need, and it is imperative to place new emphasis in this area. As noted previously, the Department of Health and Hospitals recently appointed an Assistant Secretary to lead the newly formed Office of Aging and Adult Services (OAAS). Although the OAAS is not limited to serving the mentally ill population, collaboration is the norm between OMH and OAAS. The Office of Mental Health has also been participating in a legislatively authorized Study Group on Adult Abuse and Neglect examining protective services, access to these services for both the elderly and adult populations, and legislation that impacts protective service delivery; the work of this group has been extended for an additional year.

Activities being provided for the elderly currently include those services offered by OMH through the Louisiana Spirit (LA Spirit) Hurricane Recovery Program. The LA Spirit program began providing services immediately after the hurricanes of 2005 and continues to provide expanded crisis services and education for trauma survivors today. Louisiana Spirit services include the provision of crisis counseling and resource referral services to priority populations, including older adults. These services are funded by a grant from the FEMA Crisis Counseling program administered by SAMHSA. In 2006, LA Spirit was granted the opportunity to provide specialized crisis counseling services (SCCS) as part of the CCP services and the elderly have been one beneficiary from the enhanced services. These services include cognitive behavioral interventions that are consumer driven and utilize techniques such as problem solving, goal setting and motivational enhancement.

Louisiana Spirit providers have been reaching out to priority populations since September of 2005, immediately after the hurricanes hit the Gulf Coast. LA Spirit Outreach Workers and Crisis Counselors have canvassed throughout the State offering crisis counseling services to those impacted by hurricanes Katrina and Rita. Given that the elderly are considered one of the priority populations in the State, a special emphasis was placed on reaching out to this population. LA Spirit counselors have worked with entities as varied as local Councils on Aging, Senior Living and Assisted Living sites, Senior Centers, Nursing Homes, and Transitional Living Sites where many individuals have lived since being evacuated after the storms. Counselors have provided general psychosocial educational information on healthy living after a crisis or disaster, and reactions to grief, loss, and stress to individuals and groups. During these contacts information is provided on what is 'normal' after a catastrophe as well as signs or symptoms that more intensive or additional services would be beneficial. These contacts have also provided opportunities to educate survivors about when they may benefit from mental health screening. Additionally individuals and groups are regularly informed of the availability of local mental health, health and social services in their local area.

LA Spirit has functioned very effectively as a bridge between the elderly and the communities in which they are currently residing. Since the inception of La Spirit, there have been 38,845 first contacts with the elderly (age 65 and older), and during the year ending June 2008, there have been 13,046 first contacts made with the elderly, representing 12% of all first contacts made

during that period. Overall, the greatest number of individuals seen has fallen into the 40-64 year-old age range (55,771 first time visits between July 2007 and June 2008).

The Louisiana Spirit model, as a community based approach has been in keeping with several *New Freedom Commission* goals. The program emphasizes the connection between mental health and overall health (Goal #1), and information provided has been helpful in assisting the elderly to understand this fact. Recipients of LA Spirit services have a greater appreciation of how personal health and mental health may have been impacted by the hurricanes. Rather than individuals going to sites during regular business hours, services are delivered within communities at times when members are available making it easier for them to access mental health services. Services have also been provided in survivors' homes. The Louisiana Spirit Crisis Counseling hurricane recovery program is consumer and family driven (Goal #2). The program's underpinning utilizes a model that incorporates mental health screening, assessment and referral to assistance to those who would benefit from additional services (Goal #4).

As discussed in the Housing Services Section of Criterion 1 and previously in this Criterion (see Outreach to Homeless), there are several initiatives to assist the elderly with housing. OMH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, has actively pursued the inclusion of people with disabilities in all post-disaster affordable housing development. These efforts resulted in a Permanent Supportive Housing (PSH) Initiative which successfully gained a set aside of 5% of all units developed with Low Income Housing Tax Credits to go to low income people with special needs, including the elderly population. To date, over 900 units of supportive housing are scheduled to be developed. Because people with mental illness are present to a high degree in all of the targeted subpopulations of this initiative, it is likely that they will benefit significantly. This initiative also targets the aging population so those persons with mental illness who are in that subpopulation will have targeted housing, emphasizing Goal #3 of the *President's New Freedom Commission Report*: disparities in mental health services are eliminated.

CAHSD reports that they collaborate with the Federally Qualified Health Care Centers (FQHC) regarding persons with SMI over the age of 65. Additionally, they often refer and consult with the Governor's Office of Elderly Affairs. Mobile outreach teams provide therapeutic respite and linkage to community services for adults. A local hospital provides on-site medical care at the Baton Rouge Mental Health Center on a monthly basis. In addition, the Council on Aging collaborates with CAHSD in the provision of food, transportation, and sitter services. Tyler Mental Health Center in Region IV has a registered nurse specifically assigned to the geriatric caseload. Region V has a clinical team that addresses client specific issues for older persons with SMI, as well as enhanced nursing services throughout the region dedicated to providing medical services. Region VII has specialized programming for elderly that includes five geriatric inpatient psychiatric units and four geriatric day programs. Outpatient counseling is also available specifically for this population.

Specific clinical staffing and enhanced nursing services are also noted as ways of meeting the needs of elderly persons with SMI. Other specialized initiatives and relationships mentioned included home health agencies, meals on wheels, Elderly Protection Services, Senior Citizens Centers, Council on Aging, Veterans Administration, and Housing Authority for Senior Citizens.

The Community Mental Health Block Grant for the FY 08-09 is $6,155,074 down 2.4% from the initial FY 07-08 of $6,309,615 up from the low of $5,902,412 in FY 05-06; which was reduced from the FY 04-05 level of $6,338,989. Block Grant money is used by OMH to finance innovative programs that help to address service gaps and needs in every part of the state. The Block Grant funds are divided almost equally between Adult and C/Y programs. The OMH FY 2008-2009 budget (initial appropriation) was $328,395,088. The total appropriation for the community is $85,317,232.

The following tables provide additional budgetary information, including a breakdown of federal funding for mental health services. This section also contains further information about staffing resources, etc.

OFFICE OF MENTAL HEALTH INITIAL APPROPRIATION FOR FY 08-09			
BUDGET SUB-ITEM	**SUB-ITEM DIVISIONS**	**TOTAL(S)**	**% of TOTAL**
Community Budget	CMHCs (a)	$47,635,883	15%
	Acute Units (b)	3,863,397	1%
	Social Service Contracts	33,817,952	10%
	Community Total	**$85,317,232**	**26%**
Hospital Budget	Central Louisiana State Hospital	31,092,074	9%
	Eastern Louisiana Mental Health System (c)	100,913,566	31%
	New Orleans Adolescent Hospital	24,425,456	7%
	Southeast Louisiana Hospital (d)	44,591,400	14%
	Hospital Total	**$201,022,496**	**61%**
State Office Budget	**State Office Total (e)**	**42,055,360**	**13%**
TOTAL		**$328,395,088**	**100%**
(a) Excludes Capital Area Human Services District budget, Florida Parishes Human Services Authority, Metropolitan Human Services District and Jefferson Parish Human Services Authority.			
(b) Does not include $1,250,195 for operation of the Washington-St. Tammany acute units that are located in OMH Hospitals.			
(c) East Louisiana Mental Health System is comprised of East Louisiana State Hospital, Feliciana Forensic Facility, and Greenwell Springs Hospital. Earl K. Long Hospital has been transferred to ELSH. Budgets are combined.			
(d) Includes $1,250,195 for operation of the Washington-St. Tammany acute units.			
(e) Actual appropriation is $49,358,405 of which $7,303,045 is transferred to the Community budget.			

MENTAL HEALTH FACILITIES, BEDS, FUNDING
FY 2004 - 2008

HOSPITAL SYSTEM

	FY 2004	FY 2005	FY 2006	FY 2007 (7/1/06)	FY 2008 (7/1//07)	FY 2009 (7/1/08)
Total Adult/Child State Hosp. Beds (a)	915	891	841	840	842	810
State Gen'l Funds(b) ($)	31,186,948	38,397,922	55,329,779	55,652,880	79,834,630	89,500,010
Federal Funds ($)	101,564,093	96,114,307	96,380,793	94,259,642	101,469,932	106,781,722

COMMUNITY SYSTEM

Acute Units

	FY 2004	FY 2005	FY2006	FY 2007 (7/1/06)	FY 2008 (7/1/07)	FY 2009 (7/1/08)
Total Number of Acute Beds	216	146	209**	238	215	283
State General Funds ($)	0	0	0	0	0	0
Federal Funds ($)	17,770,073	13,830,179	13,582,848	7,018,005	9,429,275	5,113,592

NOTE: 2006 figure reflects one less acute unit that was taken over by LSUHSC (EA Conway) & 44 bed unit at GSH
2007 figures includeWOM, UMC, HPL, GSH, & WST.
2008 figures exclude GSH (transferred to ELSH).

CMHCs

	FY 2004	FY 2005	FY2006	FY 2007 (7/1/06)	FY 2008 (7/1/07)	FY 2009 (7/1/08)
Total Number of CMHCs*	43	43	43	40	41	43
State General Funds ($)**	57,544,745	61,230,195	38,595,548	33,200,663	34,767,708	37,993,999
Federal Funds ($)	5,242,468	4,190,191	4,842,248	7,951,436	7,539,648	8,159,082

*Includes Centers and Clinics only – (including LGEs)
** does not include LGEs

CONTRACT COMMUNITY PROGRAMS	FY 2004	FY 2005	FY 2006	FY 2007 (7/1/06)	FY 2008 (7/1/07)	FY 2009 (7/1/08)
State General Funds ($)	5,714,427	9,630,947	7,055,555	6,063,759	12,830,006	31,144,944
Federal Funds ($)	7,829,953	5,346,843	2,472,667	23,017,891	12,871,215	3,346,292

NOTES:
(a) Staffed beds. Does not include money for operation of acute units in OMH freestanding psychiatric hospitals.
(b) Additional services for persons with mental illness were provided through the Medicaid agency:
Mental Health Rehabilitation Option

Office of Mental Health Inpatient Staffed Beds

	Intermediate Care Staffed Beds			Acute Care Staffed Beds			Grand Total
	Child/ Youth	Adult	Total Intermed Care	Child/ Youth	Adult	Total Acute Care	
Central State Hospital	28	116	144	0	0	0	144
Eastern LA Mental Health System (Jackson Campus)	0	292	292	0	66	66	358
Feliciana Forensic Facility	0	235	235	0	0	0	235
New Orleans Adolescent Hospital	15	0	15	0	30	30	45
Southeast Louisiana Hospital (Mandeville)	30	94	124	0	24	24	148
Leonard Chabert Hospital	0	0	0	0	24	24	24
EA Conway	0	0	0	0	27	27	27
Huey P Long Hospital	0	0	0	0	16	16	16
LSU – Shreveport	0	0	0	0	51	51	51
University Medical Hospital	0	0	0	0	17	17	17
Washington- St. Tammany	0	0	0	0	18	18	18
W.O. Moss	0	0	0	0	10	10	10
TOTAL	73	737	810	0	283	283	1093

Based on Patient Movement Reports Updated 7/30/07 tc

TOTAL NUMBERS OF HOSPITAL INTERMEDIATE CARE BEDS BY FACILITY (6/30/08)

	Licensed	Staffed	% Staffed	% Occupancy
CLSH	196	144	74%	90.20%
ELSH	362	292	80.70%	99.70%
SELH	374	124	40.40%	91.90%
FFF	235	235	100%	100%
NOAH	102	15	14.70%	80.20%
TOTAL	1269	810	--	--

Based on Patient Movement Data 7/1/08tc

OMH WORKFORCE ON LAST DAY OF FY 2003 – 2008

Organizational Unit	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	Increase / [Decrease]
Community System: Regions & LGEs							
MHSD	334	106	120	154	87	107	20
CAHSD	98	118	125	163**	281**	181	[100]
Region 3	71	73	83	71	70	77	7
Region 4	133	129	134	126	125	131	6
Region 5	78	76	79	59	57	53	[4]
Region 6	90	90	106	101	96	104	8
Region 7	79	75	95	77	67	79	12
Region 8	110	62	72	73	58	62	4
FPHSA	52	62	66	60	94	97	3
JPHSA	67	67	60	70	73**	86	13
Community Sub- Total	**947**	**858**	**940**	**954**	**1,008**	**977**	**[31]**
OMH Operated State Hospitals							
CLSH	389	368	351	347	316	371	55
ELMHS	1,268	1,249	1,245	1,176	1,227	1,285	58
NOAH	168	158	163	96	172	255	83
SELH	533	479	518	394	442	593	151
State Hospital Sub-Total	**2,358**	**2,254**	**2,277**	**2,013**	**2,157**	**2,504**	**347**
State Office*	**105**	**130**	**168**	**175**	**349***	**430***	**81**
Statewide Total	**3,410**	**3,242**	**3,385**	**3,142**	**3,514**	**3,911**	**397**

KEY: **CLSH** = Central Louisiana State Hospital
ELMHS = Eastern Louisiana Mental Health System (ELMHS) - includes Greenwell Springs Hospital, East Division, & Forensic Division
NOAH = New Orleans Adolescent Hospital
SELH = Southeast Louisiana Hospital

NOTES: Count is of TO Positions

*The large increase in State Office numbers in 2003-06 is due to the inclusion of the staff of ECSS, Prior Authorization, and LaYes, and in FY 07 & 08 also LA Spirit.

**Includes Social Services Block Grant positions

Numbers of Community Professional Staff Members by Discipline on June 30, 2008

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/ PharmD
Region/LGE		Doctoral*	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters	Bachelors	
MHSD**	15 (13 FTE)	4	0	0	32	0	10	0	2	23	0
CAHSD	17 (11.5 FTE)	2	0	0	86	2	9 (6.23 FTE)	4	8	3	0
III	15 (11.6 FTE)	2 (1.6 FTE) 1 MP*	0	0	10	2(1.8 FTE)	9	2	11	3	0
IV	6 (5.5 FTE)	2 (0.4 FTE)	7	0	30	0	0	9	0	4	0
V	1 (0.2 FTE)	2 (1.2 FTE)	3	0	7	0	3	0	6	2	1 (0.2 FTE)
VI	4	0	5	0	9	0	4	6	2	2	0
VII	10 (7.9 FTE)	2 (0.6 FTE)	4	0	15	0	3	3	9	2	0
VIII	5 (3.8 FTE)	2 (0.4 FTE)	0	0	18	0	4	5	7	2	0
FPHSA	8 (5.4 FTE)	1 (0.1 FTE)	0	0	33 (32.2 FTE)	0	2	3	3	0	1
JPHSA	16 (14.4 FTE)	2	0	0	74	4	8	6	14 (13.3)	3	0
Total By Discipline	**97(77.3FTE)**	**20(13.3FTE)**	**19**	**0**	**314(313.2FTE)**	**8(7.8FTE)**	**52(49.23FTE)**	**38**	**62(61.3FTE)**	**44**	**1(0.2FTE)**

NOTES: (FTE listed only if not full-time) * MP: Medical Psychologist

**** Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

Numbers of OMH Hospital Professional Staff Members by Discipline on June 30, 2008

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/ Doctorate
Hospital		Doctoral*	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters	Bachelors	
CLSH	4.5	3	2	0	8	1	13	43	0	4	0
ELMHS	19.2	14	2	0	42	5	64	75	0	4	2
NOAH	4	2	0	0	17	3	19	2	2	3	0
SELH	0	10	2	0	5	3	18	30	2	6	1
Total by Discipline	**27.7**	**29**	**6**	**0**	**72**	**12**	**114**	**150**	**4**	**17**	**3**

Note: (FTE listed only if not full-time) * MP: Medical Psychologist

OMH Community Total Prescribing Workforce on June 30, 2008

Psychiatric Type	Total Number FTE Psychiatrists		Of Total Psychiatry FTE, Number Certified Child Psychiatrists		Total Number FTE Medical Psychologists		Total Number FTE Nurse Practitioners	
Region/ LGE	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract
MHSD*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CAHSD	11	2.3	2	0				
3	10	1.6	0	0.4				0.7
4	6	1.2	1	0		0.4		
5	0.2	0	0	0		0.2		
6	4	2.62	1	0				
7	6.8	1.05	0	.65				
8	3	0.8	0	0				
FPHSA	4	1.4	0	0				
JPHSA	10.4	1.41	2.95	.80				

*** NOTE: Due to the management restructuring in MHSD this data is not available for the fiscal year 2008.**

OMH Hospital Psychiatric Workforce on June 30, 2008

Psychiatric Type	Number FTE Psychiatrists Serving Adults/ Children		Number FTE Certified Child Psychiatrists		Hospital FTE Total Psychiatrists
Hospital	Civil Service	Contract	Civil Service	Contract	
CLSH	3.5	1.25	0	.25	4.75
ELMHS	0	19.2	0	2	19.2
NOAH	3	10	3	3	13
SELH	7	16	0	1	23
Totals	**13.5**	**46.45**	3	6.25	**59.95**

KEY: CLSH = Central Louisiana State Hospital
ELMHS = Eastern Louisiana Mental Health System (ELMHS): Greenwell Springs Hospital, East Division, Forensic Division
NOAH = New Orleans Adolescent Hospital
SELH = Southeast Louisiana Hospital

OMH Community Staff Liaisons on June 30, 2008

Region/ LGE	FTE Child/Youth Family Liaisons	FTE Adult Consumer Liaisons
MHSD*	1	VACANT
CAHSD	1	0.5
III	0.8	0.8
IV	0.8	0.8
V	0.2	0.8
VI	0.5	0.6
VII	1	1
VIII	0.5	0.5
FPHSA	VACANT	0.8
JPHSA	1	0.4

(a) Includes civil service and contract employees

*** NOTE: Due to the management restructuring in MHSD this data is not yet available for the fiscal year 2008, and the FY 2007 data has been inserted into this table. It is believed that using these numbers will result in the most valid interpretation available at this time.**

All Regions/ LGEs report difficulties providing necessary services due to a workforce shortage. In addition to the usual problems, for the first time, high gasoline prices are being mentioned as deterrents to successful workforce development and maintenance. Previously, it had been noted that many healthcare professionals left state government jobs or literally left Louisiana after the hurricanes, for better pay and better working conditions. Although exceptions were considered, a hiring freeze instituted by Governor Bobby Jindal shortly after his inauguration further exacerbated employment problems. Workforce vacancies have affected all aspects of direct service: medical, nursing, counseling, and clerical. The shortage has had a serious effect on the number of clients seen, the length of time from first contact to psychiatric evaluation, medication management, and counseling. There is a shortage of community resources to fill service gaps. To fill the gaps in prescribers, some regions have successfully contracted with non-physician prescribers, specifically, Medical Psychologists and/or Nurse Practitioners. Others have used locum tenens physicians.

Recruitment efforts have included contacting medical recruitment agencies, advertisements in professional journals, newspapers, as well as contacting psychiatric residency and graduate school programs.

CRITERION 5
MANAGEMENT SYSTEMS – EMERGENCY SERVICE PROVIDER TRAINING AND EMERGENCY SERVICE TRAINING TO MENTAL HEALTH PROVIDERS
LOUISIANA FY 2009 - ADULT & CHILD/YOUTH PLAN

OMH makes available a variety of mental health training to providers of emergency services, *as well as* emergency services trainings to mental health providers. Post Hurricanes Katrina and Rita, LGEs and Regions have partnered with and participated in numerous trainings with the Office of Public Health, FEMA, community agencies, and local emergency command centers. Thousands of hours of service time was given to emergency preparedness and response via general shelters, special needs shelters, mobile crisis teams, and in other venues for many months following these hurricanes. After the initial response, regional 'after action' conferences were held throughout the state to review and assess the work done over the previous months. Among the lessons learned from the hurricanes, modifications to preparedness training have included better delineation of responsibilities between offices, persons' roles, locations of services, and other technicalities. Evacuation procedures and plans have been more closely detailed in the event of a crisis. Collaboration with other state agencies, non-profit agencies, and other organizations on parish and local levels has occurred. Continuity of operations plans for all OMH facilities have been drafted.

Effective emergency management and incident response activities begin with a host of preparedness activities conducted on an ongoing basis, in advance of any potential incident. Preparedness involves an integrated combination of planning, procedures and protocols, training and exercises. The Division of Emergency Preparedness prepares the Office of Mental Health (OMH) to respond rapidly and effectively to natural and man-made disasters, including terrorism**.** A variety of mental health trainings are offered to providers of emergency services, as well as emergency response trainings to mental health providers to support efforts to strengthen its emergency response capabilities and disaster mental health resources statewide.

Local Governmental Entities (LGEs) and Regions continue to partner with and participate in trainings through the Office of Public Health, FEMA, community agencies, and local emergency command centers. Thousands of hours of service time was given to emergency preparedness and response via general shelters, special needs shelters, mobile crisis teams, and in other venues. Evacuation procedures and plans have been more closely detailed in the event of a crisis. Collaboration with other state agencies, non-profit agencies, and other organizations on parish and local levels has occurred. Continuity of operations plans for all OMH facilities have been drafted.

OMH has a Call-Out system for all personnel to staff special-needs shelters in the event of a natural or man-made disaster, and conducts routine training and drills in these procedures. Training includes the use of FEMA assistance sites, evacuation of OMH patients, delivery of medication and medication management, and related mental health needs. All CMHC staff members receive training in mental health disaster response that addresses all age groups. All Office of Mental Health staff members were required to take the FEMA sponsored National Incident Management System Training (NIMS). Additionally, various staff members have been trained in Medical Special Needs Shelter Operations.

The following documents activities by the Office of Mental Health and/or its affiliates. All trainings are culturally competent and age/gender-specific to the population served in alignment with Goal 1 and Goal 3 of the *President's New Freedom Commission Report*.

- OMH hosted its first Behavioral Health Hurricane Summit in collaboration with the Office of Public Health (OPH), Office for Addictive Disorders (OAD) and the Office for Citizens with Developmental Disabilities (OCDD). The event was offered to enhance current behavioral health disaster response plans for OMH, OAD and OCDD facilities with participation from regional and local first responders and public health.
- Hurricane preparedness and Shelter-in-Place Drills were conducted as a training exercise with OMH hospitals and mental health clinics across the State. These drills provided a learning venue for emergency service providers to help them better understand the impact of mental illness and to increase their skill capability to respond to emergencies in the behavioral health care community in an inpatient and outpatient environment. All trainings are culturally competent and age/gender-specific to the population served in alignment with Goal 1 and Goal 3 of the President's New Freedom Commission Report.
- OMH jointly with the Office of Public Health and the Governor's Office of Homeland Security and Emergency Preparedness provides ongoing training to parish level police/fire/EMS workers charged with disaster response duties, i.e., critical incident management, mental health disaster services, bio-terrorism preparedness, mental health response to mass casualties, coordination of mental health and first responders training, stress management for first responders, and psychological first aid training.
- Crisis Intervention Training (CIT) was conducted with law enforcement agencies in the New Orleans and Lake Charles areas in 2005 and 2006. Additionally, OMH works in partnership with key community organizations such as Southern Law Enforcement Critical Incident Stress Management (CISM), and provides training on crisis intervention techniques to first responders, and assists with outreach needs in crisis events. OMH also participates with the New Orleans Police Department and Tulane Hospital to provide Intervention Specialist Officer training to law enforcement, emphasizing crisis intervention with the mentally ill. Training on mental health issues, including dealing with violence, is provided by OMH staff members to the Coroner's Task Force Members, comprised of individuals from Coroners' Offices, Sheriffs' Departments, City Police Departments, and other local law enforcement authorities in most OMH regions and LGEs.
- Behavioral health trainings are provided routinely at the state Emergency Operations Center (EOC) to emergency operations personnel prior to and during a declared disaster.
- Various planning, preparedness, mitigation and recovery exercises are regularly conducted.
- OMH recently participated in a mock pandemic flu exercise that was conducted in conjunction with the Office of Public Health.

Other agency sponsored services include:

- Preventative programs such as the Louisiana Partnership for Youth Suicide Prevention (LPYSP). OMH hosted a Youth Suicide Prevention Summit in April 2006 to bring issues of suicide among youth in Louisiana forward. In 2006, Louisiana was awarded funds under the Garrett Lee Smith Memorial Act from Substance Abuse and Mental Health Service Administration (SAMHSA) to implement statewide youth suicide intervention and prevention strategies. Applied Suicide Intervention Specialist Training (ASIST) is one of several trainings to be provided by this funding initiative over the next 3 years. The ASIST project will be offered across the state to all communities, including government agencies, consumer/advocacy agencies, emergency service providers, schools and families to help reduce the incidence of suicide in Louisiana.

- Stress management and self-care education and skill building to the first responder's network throughout the state, via the LA Spirit program. LA Spirit hosted a Disaster Mental Health training *"Moving Forward Plan"* for first responders in January 2006. A second training, *"Making Progress"* was held in March 2007 to raise awareness among first responders of psychological issues and trauma experienced during catastrophic events. Also in 2007, the first statewide training of first responder teams was provided in Baton Rouge, with presentations by the New York Fire Department Counseling Services Unit. This peer training provided tools to assist first responders when in the field. Video conferences with first responder teams throughout Louisiana are held monthly.

Please see Criterion 1 for information about the *Louisiana Spirit Hurricane Recovery Program*, the federally funded Crisis Counseling Assistance and Training Program, that is focused on addressing post-hurricane disaster mental health needs and other long term disaster recovery initiatives.

More specific examples of emergency services response include:

OMH provides staff members in all state-administered hospital emergency rooms. These staff members perform mental health screening as part of the admission process. OMH coordinates in-service training for emergency room doctors, nurses and other professional and para-professional staff. OMH also trains teachers and school administrators in disaster response procedures.

OMH, jointly with the Office of Emergency Preparedness, provides training to parish level police/ fire/ EMS workers charged with disaster response. Such training includes:

> Critical incident management, Mental health disaster services, Bio-terrorism preparedness, Mental health response to mass casualties, Coordination of mental health and first responders, Stress management for first responders.

In perhaps the best example statewide, CAHSD reports that they are very engaged and involved in activities involving crisis and emergency planning. They convened a Community Stakeholder Collaborative in the summer of 2007 to develop plans to alleviate the behavioral health crises within the community, and a resulting response plan was developed. CAHSD has developed a ten component continuum to address the behavioral health crisis needs in the community; including a set of triage screening tools. The Collaborative includes a crisis Intervention Team Training for law enforcement, having trained 21 law enforcement agents in January 2008, and plans for training another 24 in the summer of 2008. For many years, CAHSD has provided training to law enforcement on behavioral health and developmental disabilities and has expanded this role to include first responders in the community. CAHSD also has a well-defined response plan for bioterrorism, pandemic flu, and other mass disasters. CAHSD has a collaborative relationship with the local chapter of the Red Cross, Office of Homeland Security, Emergency Preparedness, as well as other emergency management organizations. CAHSD drills, meets and exercises with these entities to ensure an understanding of roles and responsibilities, operations, etc.

In addition, Crisis Intervention Training (CIT) is occurring in several regions statewide, with plans to take it statewide, training officers and dispatchers to assess and respond appropriately to calls involving adults with SMI and children with EBD. Other preparedness activities include monthly statewide Disaster videoconferences, NIMS training, monthly 800 Mhz radio checks, and on-going dialogue with Office of Public Health.

INTENDED USE PLAN BY SERVICE CATEGORY
FY 2009 - ADULT PLAN

ADULT INTENDED USE CATEGORIES & ALLOCATIONS

Service Category	Types of Services	Region/ LGE	Area	State Office	Total Allocation
Adult Employment	Employment Programs; Development & Services	$109,970	$0	$61,592	$171,562
Advisory Council Support	RAC Support	32,435	0	0	32,435
Assertive Community Treatment (ACT)	ACT Outreach Services	136,857	0	0	136,857
Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support, Supported Adult Education	6,000	0	49,720	55,720
Consumer Liaisons	Consumer Liaisons (not in contracts)	118,334	0	0	118,334
Consumer Monitoring and Evaluation	MIS; Consumer-Directed Service System Monitoring, Consumer Liaisons:	5,278	16,282	63,484	85,044
Consumer Support Services	Consumer Initiated Programs, Consumer-Education, Community Care Resources; Community Resource Centers, Case Management; Consumer Support; Medicaid Enrollment; Support and Empowerment	625,945	0	418,566	1,044,511
Crisis Response Services	Crisis Line, Crisis Stabilization, Crisis 24 hour screening & assessment, Mobile crisis response	21,380	0	0	21,380
Mental Health Treatment Services	Psycho-social Day Treatment; Forensic Program, Co-occurring Disorders Treatment	25,507	0	0	25,507
Planning Operations & System Development	Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement; Planning Council Office: Support Staff, Office Operations, member travel and training, MIS	0	0	255,857	255,857
Residential / Housing	Housing Development and Services; Foster Care; Group Homes Supervised Apartments; 24-hour residential Housing Support Services	338,032	0	0	388,032
Respite	Respite Services and Supports	0	0	0	0
Staff Development	OMH Workforce Recruitment, Development and Retention, Staffing for Bureau of Workforce Development	0	0	122,701	122,701
Transportation	Community / Rural Transportation	20,560	0		20,560
Other Contracted Services	Comprehensive Mental Health Services; MIS Infrastructure Development; PODS (Public Outreach Depression Screening)	161,390	85,955	139,515	386,860
Other	Forensic Services	0	350,000	0	350,000
TOTAL		**$1,601,688**	**$452,237**	**1,111,435**	**3,165,360**

INTENDED USE PLAN BY SERVICE CATEGORY
FY 2009 – CHILD/YOUTH PLAN

C/ Y/ F INTENDED USE CATEGORIES & ALLOCATIONS

Service Category	Types of Services	Region/ LGE	Area	State Office	Total Allocation
Advisory Council Support	RAC Support	$32,500	$0	$0	$32,500
Assertive Community Treatment	ACT Outreach Services	193,749	0	0	193,749
Consumer Advocacy and Education	Consumer Education; Advocacy and Education; Family Organization Support	7,519	0	$22,000	29,519
Consumer Liaisons	Consumer Liaisons (not in contracts)	70,924	0	0	70,924
Consumer Monitoring and Evaluation	MIS; Consumer-Directed Service System Monitoring, Consumer Liaisons:	70,210	16,283	80,000	166,493
Crisis Response Services	Crisis Line, Crisis Stabilization, Crisis 24 hour screening & assessment, Mobile crisis response	203,996	0	0	203,996
Family Support Services	Family Support Services; Wraparound; Family Mentoring Program; Family Support Liaison and Program; Medicaid Enrollment; Parent Mentoring; Nurse Visitation Program, Parent Liaisons, Mentoring, Community Care Resources; Rural Mobile Outreach Programs, Family Training, Therapeutic Camp	699,624	0	57,240	756,864
Planning Operations and Systems Development	Staffing for Bureau of Planning, Performance Partnerships and Stakeholder Involvement, Planning Council Office: Support Staff, Office Operations, member travel and training, MIS	0	0	190,857	190,857
Residential / Housing	Housing Development and Services; Foster Care; Group Homes; Supervised Apartments Housing 24-hour residential Housing Support Services	0	0	0	0
Respite	Respite Programs	303,841	0	0	303,841
School-Based Mental Health Services	School-Based Clinic; School-Based Services, School Violence Prevention	114,470	0	0	114,470
Staff Development	OMH Workforce Recruitment, Development and Retention, Staffing for Bureau of Workforce Development	0	0	217,061	217,061
Transportation	Community / Rural Transportation	174,857	0	0	174,857
Other Contracted Services	Comprehensive Mental Health Services, Nurse Home Visitation Program, MIS Infrastructure Development, PODS (Public Outreach Depression Screening)	374,068	0	160,515	534,583
TOTAL		**$2,245,758**	**$16,283**	**727,673**	**2,989,714**

INTENDED USE PLAN SUMMARY BY REGION / LGE

LOUISIANA FY 2009 - ADULT & CHILD/YOUTH PLAN

Allocation Summary by Region / Local Governing Entity/ Area/ State Office

Region/ LGE	Adult	Child/ Youth	TOTAL
MHSD	$ 117,550	$ 367,848	$ 485,398
CAHSD	$ 194,798	$ 280,319	$ 475,117
Region 3	$ 197,242	$ 225,339	$ 422,581
Region 4	$ 200,450	$ 241,785	$ 442,235
Region 5	$ 151,745	$ 278,786	$ 430,531
Region 6	$ 170,384	$ 246,415	$ 416,799
Region 7	$ 180,082	$ 189,302	$ 369,384
Region 8	$ 193,971	$ 193,971	$ 387,942
FPHSD	$ 149,078	$ 187,900	$ 336,978
JPHSA	$ 46,388	$ 34,093	$ 80,481
Reg Total	**$ 1,601,688**	**$ 2,245,758**	**$ 3,847,446**
Area A	15,253	15,254	30,507
Area B	436,984	1,029	438,013
Area C	0	0	0
Area Total	**$ 452,237**	**$ 16,283**	**$ 468,520**
SUBTOTAL	**$ 2,053,925**	**$ 2,262,041**	**$ 4,315,966**
State Office	**$1,111,435**	**$727,673**	**$1,839,108**
TOTAL			**$ 6,155,074**

Percentage of Block Grant Dollars Allocated to Adults:	**51.4%**
Percentage of Block Grant Dollars Allocated to Children/ Youth :	**48.6%**

Intended Use Plan Notes

If circumstances occur that prohibit expenditure of any portion of the Block Grant funds as intended, OMH will utilize the remaining funds for the purchase of Block Grant related equipment and supplies (e.g. computers, printers, software, fax machines, projectors, tele-communication equipment/infrastructure/staff, etc.) and/or Phase IV medications and/or other appropriate expenditures.

The allocation to the Jefferson Parish Human Services Authority appears inconsistent with other regions because when the Authority was created their Block Grant dollars were replaced with State General Funds. Since then, this situation has been considered when new Block Grant dollars have been awarded or when funding has been decreased.

Complete details of the Intended Use Plans submitted from each Region, LGE, Area, and State Office is included in Appendix A of this document.

Table C
MHBG FUNDING FOR TRANSFORMATION ACTIVITIES -

	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY 2009.	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	✓	N/A	$365,050
GOAL 2: Mental Health Care is Consumer and Family Driven	✓	N/A	$2,109,058
GOAL 3: Disparities in Mental Health Services are Eliminated	✓	N/A	$729,854
GOAL 4: Early Mental Health Screening, Assessment, and referral to Services are Common Practice	✓	N/A	$2,132,312
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	✓	N/A	$151,475
GOAL 6: Technology Is Used to Access Mental Health Care and Information	✓	N/A	$667,325
Total MHBG Funds		N/A	**$6,155,074**

*Goal 5 of the Final Report of the *President's New Freedom Commission on Mental Health* states: *Excellent mental Health Care is Delivered and Research is Accelerated*. CMHS is authorized to conduct evaluations of programs and not research.

DESCRIPTION OF TRANSFORMATION ACTIVITIES

NOTE: Transformation activities are prominently highlighted throughout the text of this document. Additionally, see the *New Freedom Commission & OMH Intended Use Categories Service Crosswalk* in Section II. This crosswalk highlights the efforts that Louisiana has taken to ensure that all Goals of the New Freedom Commission are addressed.

LOUISIANA FY 2009
BLOCK GRANT PLAN

Part C
STATE PLAN
Section III

PERFORMANCE INDICATORS,
GOALS, TARGETS AND ACTION PLANS

ADULT PLAN

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities **XX**

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	24,667	25,604	27,619	26,000
Numerator	--	--	--	--
Denominator	--	--	--	--

Table Descriptors:

Goal: Adults who have been identified as having serious mental illness will have access to state mental health services

Target: Access to mental health services will be provided for a greater number of adults with serious mental illness

Population: Adults diagnosed with a Serious Mental Illness

Criterion:2: Mental Health System Data Epidemiology

Indicator: The number of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. NOMS Indicator # 1

Measure: Estimated unduplicated count of adults (on caseload on the last day of the fiscal year) who have serious mental illness and who receive mental health services during the fiscal year (7/1 - 6/30) in an OMH community or inpatient setting.

Sources of Information: CMHC-ARAMIS, PIP

Special Issues: NOTE: 1) In the past, this indicator has been reported as the percentage of prevalence of adults who have a serious mental illness who receive mental health services from the Office of Mental Health during the fiscal year. These numbers are discussed in Criterion 2 of the Plan. In order to be consistent with NOMS Indicators, the measure is now reported as a number rather than as a percentage. 2) Until FY 2008, the numbers reported for this indicator did not include Jefferson Parish Human Services Authority (JPHSA), as this information was not available.

Due to the hurricanes of 2005, the population of the State has fluctuated, and in some areas, there has been a shortage of available services due to infrastructure and workforce problems. These factors make predictions and target-setting particularly difficult. Targets continue to be set conservatively, of necessity. The FY 2008 actual figure is 27,619.

Significance: Setting quantitative goals to be achieved for the numbers of adults who are seriously mentally ill to be served in the public mental health system is a key requirement of the mental health Block Grant law

Action Plan: The Block Grant indicators will be monitored through the OMH Quality Council and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Quality Council sponsors a quarterly Quality Forum that is designed to review OMH performance indicators and provide a venue for dialogues on system quality improvement strategies and action plans. The Forum is attended by a wide range of mental health stakeholders, including hospital and community quality management staff, and consumers and family members. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	2.48%	4.8%	3.7%	4.0%
Numerator	8	29	10	
Denominator	322	600	274	

Table Descriptors:

Goal: The Office of Mental Health will improve the quality of care that is provided.

Target: The number of adults who are discharged from a state hospital and then re-admitted will either decrease or be maintained (30 days).

Population: Adults diagnosed with Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of consumers discharged from state psychiatric hospitals and re-admitted to an Office of Mental Health inpatient program within thirty (30) days of discharge. NOMS Indicator #2

Measure: 30 Day Rates of Discharge and Re-admission
Numerator = # Readmits to PIP State Hospital within 30 days
Denominator = # Patients Discharged from PIP State Hospital (not-unduplicated)
Calendar year (Jan 1 - Dec 31)

Sources of Information: Patient Information Program (PIP)

Special Issues: Comparisons from year to year are difficult given changes in data collection that will be standard from this year forward. Prior to the 2007 fiscal year, the total number of discharges from state hospitals excluded patients in all Acute Units, patients on leave, Forensic (FFF) patients, and patients discharged to another state hospital. Fiscal year 2007 data included discharges from acute units *within* the hospitals, and only free-standing acute units were excluded. Beginning in FY 2008, *all* acute unit discharges (within hospital and free-standing) are excluded. These variances in data collection may explain the 2007 denominator being higher than in other years. As a result of the hurricanes in 2005, the number of available hospital beds decreased due to infrastructure and staffing problems, and the functioning of many previously stable mentally ill individuals deteriorated; thus affecting the 2006 & 2007 statistics. There are many hypothetical reasons for the decrease that was apparent in the FY 2006 numbers, but the true reason is unknown. For example, it may be that people left the state after discharge due to problems with housing, etc. While the service system continues to stabilize, this target is again being set conservatively. FY 2008 Actual: 10/274 X 100 = 3.7%

Significance: Recidivism is one measure of treatment effectiveness.

Action Plan: The Block Grant indicators will be monitored through the OMH Quality Council and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Quality Council sponsors a quarterly Quality Forum that is designed to review OMH performance indicators and provide a venue for dialogues on system quality improvement strategies and action plans. The Forum is attended by a wide range of mental health stakeholders, including hospital and community quality management staff, and consumers and family members. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	8.70	10.67	12%	12%
Numerator	28	64	33	
Denominator	322	600	274	

Table Descriptors:

Goal: The Office of Mental Health will improve the quality of care that is provided.

Target: The number of adults who are discharged from a state hospital and then re-admitted will either decrease or be maintained (180 days).

Population: Adults diagnosed with Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of consumers discharged from state psychiatric hospitals and re-admitted to an Office of Mental Health inpatient program within 180 days of discharge. NOMS Indicator #2

Measure: 180 Day Rates of Discharge and Re-admission
Numerator = # Readmits to PIP State Hospital within 180 days
Denominator = # Patients Discharged from PIP State Hospital (not-unduplicated)
Calendar year (Jan 1 - Dec 31)

Sources of Information: Patient Information Program (PIP)

Special Issues: Comparisons from year to year are difficult given changes in data collection that will be standard from this year forward. Prior to the 2007 fiscal year, the total number of discharges from state hospitals excluded patients in all Acute Units, patients on leave, Forensic (FFF) patients, and patients discharged to another state hospital. Fiscal year 2007 data included discharges from acute units *within* the hospitals, and only free-standing acute units were excluded. Beginning in FY 2008, *all* acute unit discharges (within hospital and free-standing) are excluded. These variances in data collection may explain the 2007 denominator being higher than in other years. As a result of the hurricanes in 2005, the number of available hospital beds decreased due to infrastructure and staffing problems, and the functioning of many previously stable mentally ill individuals deteriorated; thus affecting the 2006 & 2007 statistics. There are many hypothetical reasons for the decrease that was apparent in the FY 2006 numbers, but the true reason is unknown. For example, it may be that people left the state after discharge due to problems with housing, etc. FY 2008 Actual: 33/274 X 100 = 12%.

Significance: Recidivism is one measure of treatment effectiveness.

Action Plan: The Block Grant indicators will be monitored through the Planning Evaluation and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Housing (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	109	23	68	68
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI who receive supported housing when appropriate as treatment goals dictate, will increase.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Supported Housing services.
NOMS Indicator #3

Measure: Number of adults with SMI who receive Supported Housing services.

Sources of Information: Survey of Regions and Districts and Survey of Hospitals

Special Issues: Information from surveys is based on Region & LGE report, and EBPs are not evaluated for fidelity. Although fidelity is uncertain, the state will use the FY2006 number as the baseline. This was a new indicator in 2006. The reason for the different figures in 2006, 2007, and 2008 may have to do with the fluctuations in housing initiatives post-hurricanes, such as the FEMA housing villages, and programs such as the Road Home and LA Spirit; and the lack of fidelity. FY2008 Actual = 68

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on the EBPs, proper treatment focus, and accurate measurement will be a focus. The expectation is that data collected on EBPs held to fidelity will be more useful. The Block Grant Indicator will be monitored through the Planning, Evaluation, and Information Technology Division and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

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ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	28	31	86	86
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Supported Employment will increase

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Supported Housing services. NOMS Indicator # 3

Measure: Number of adults with SMI who are receiving Supported Employment services

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. This was a new indicator in 2006. The reason for the different figures in 2006, 2007, and 2008 may have to do with the fluctuations in employment initiatives post-hurricanes; and the lack of fidelity. FY 2008 Actual = 86

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on the EBPs, proper treatment focus, and accurate measurement will be a focus. The expectation is that data collected on EBPs held to fidelity will be more useful. The Block Grant indicators will be monitored through the Division of Planning, Evaluation and Information Technology and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

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ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Assertive Community Treatment (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	59	230	158	158
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Assertive Community Treatment will increase

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Assertive Community Treatment services. NOMS Indicator #3

Measure: Number of adults with SMI who receive Assertive Community Treatment services

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region & LGE report and EBP's are not evaluated for fidelity. This was a new Indicator in 2006. It was expected that this EBP would be utilized more during the 2007 fiscal year; thus, the 2007 number was significantly higher than the 2006 figure. It was hoped that statewide trainings would result in increased numbers; however, continued workforce shortages have continued to be problematic in the field, resulting in a decrease in FY2008. Acknowledging this, the target has been set conservatively.
FY 2008 = 158.

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: Assertive Community Treatment is an EBP that is a priority in the Regions and LGEs. The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on the EBPs, proper treatment focus, and accurate measurement will be a focus. The expectation is that data collected on EBPs held to fidelity will be more useful. The Block Grant indicators will be monitored through the Division of Planning, Evaluation and Information Technology, and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Psychoeducation (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	766	114	192	190
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Family Psychoeducation will increase

Population: Adults diagnosed with a serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Family Psychoeducation. NOMS Indicator #3

Measure: Number of adults with SMI who receive Family Psychoeducation

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. This was a new Indicator in FY 2006. It is probable that the number initially went down because many of the practices that were described as Family Psychoeducation were not in actuality true Family Psychoeducation. FY 2008 Actual = 192.

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on the EBPs, proper treatment focus, and accurate measurement will be a focus. The expectation is that data collected on EBPs held to fidelity will be more useful. The Block Grant indicators will be monitored through the Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	746	306	1037	1000
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Integrated Treatment of Co-Occurring Disorders - Mental Illness / Substance Abuse (MISA) will increase

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Integrated Treatment of Co-Occurring Disorders. NOMS Indicator #3

Measure: Number of adults with SMI who receive Integrated Treatment of Co-Occurring Disorders; Mentally ill / Substance abuse (MISA)

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region & LGE report, and EBP's are not evaluated for fidelity. Although the fidelity of this EBP is uncertain, the State will use the FY2006 measure as a baseline. The EBP that is used in Louisiana is the LITS model that has been discussed in this document. LITS has been supported by the CoSIG grant and shows to be a promising, empirically-based practice in research. LITS is similar, although not identical to the model suggested by SAMHSA. This was a new Indicator in 2006. It is probable that the number went down because many of the practices that were described were not in actuality evidence-based. Other regions are on their way to implementing programs, but it is unlikely that they will be serving clients for another year or more. FY 2008 Actual = 1,037.

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on the EBPs, proper treatment focus, and accurate measurement will be a focus. The expectation is that data collected on EBPs held to fidelity will be more useful. The Block Grant indicators will be monitored through the Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Illness Self-Management (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	1464	661	1146	1000
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI receiving Illness Self-Management will increase

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Illness Self-Management services.
NOMS Indicator #3

Measure: Number of adults with SMI who receive Illness Self-Management services

Sources of Information: Survey of Regions & Districts, Survey of Hospitals

Special Issues: Information from surveys is based on Region & LGE report and EBP's are not evaluated for fidelity. Although the fidelity of this measure is uncertain, the state will use the FY 2006 actual number as the baseline. This was a new Indicator in 2006. It is possible that these numbers fluctuate because many of the practices that were counted are not in actuality evidence-based, or held to fidelity. FY 2008 Actual = 1146

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on the EBPs, proper treatment focus, and accurate measurement will be a focus. The expectation is that data collected on EBPs held to fidelity will be more useful. The Block Grant indicators will be monitored through the Division of Planning, Evaluation & Information Technology and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Medication Management (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	1,464	5,746	1,090	1,000
Numerator	--	--	--	
Denominator	--	--	--	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The number of adults with SMI who receive Medication Management services.

Population: Adults diagnosed with serious mental illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adults with SMI who receive Medication Management services. NOMS Indicator #3

Measure: Number of adults with SMI who receive Medication Management services

Sources of Information: Survey of Regions & Districts, Survey of Hospitals.

Special Issues: Information from surveys is based on Region and LGE report, and EBP's are not evaluated for fidelity. This was a new Indicator in 2006, and the number increased dramatically in FY2007. In 2007, a policy was put into place that changed the requirements for medication informed consent, and this may have given the appearance of inflating the numbers of clients who received this as an EBP. The Target is being set conservatively. FY 2008 Actual = 1,090.

Significance: Evidence-based practices have been shown to be effective and efficient treatment modalities that lead to positive outcomes.

Action Plan: The EBPs that have been offered and that were reported on the surveys have not all been held to fidelity. Because measurement of EBPs not held to fidelity may not be meaningful, education on the EBPs, proper treatment focus, and accurate measurement will be a focus. The expectation is that data collected on EBPs held to fidelity will be more useful. The Block Grant indicators will be monitored through the Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	98.31%	99%	99%	99%
Numerator	1,221	922	1067	
Denominator	1,242	927	1080	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: Consumers will rate the quality and appropriateness of care they are being provided by the Office of Mental Health positively

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of Office of Mental Health consumers who rate the quality and appropriateness of services as positive. NOMS Indicator # 4

Measure: Numerator: Number of OMH consumers surveyed during the fiscal year (7/1 - 6/30) through C'est Bon process that report an overall grade of C or better. Denominator: Total number of OMH consumers surveyed.

Sources of Information: C'est Bon Survey: Items 5, 9-10, 12-13, 15-17, 29

Special Issues: This indicator was reduced with input from the Planning Council after Hurricanes Katrina and Rita. With fewer available services and greater wait times (due to closed clinics and less staff) it was expected that clients would rate their care as less satisfactory. The indicator is suggested by CMHS resulting in data appropriate for national comparisons.

Definitions: C'est Bon: Consumer Evaluation of Service Team

C'est Bon Process: Consumer-to-consumer administered survey adapted from MHSIP Report Card prototype and piloted in Louisiana

The target will remain high, given the importance of this measure. FY 2008 actual: 1,067/1,080 X 100 = 99%

Significance: Persons receiving mental health services should be satisfied with those services; and evaluation of quality and appropriateness of care are valid measures of satisfaction

Action Plan: The Block Grant indicators will be monitored through the OMH Quality Council and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Quality Council sponsors a quarterly Quality Forum that is designed to review OMH performance indicators and provide a venue for dialogues on system quality improvement strategies and action plans. The Forum is attended by a wide range of mental health stakeholders, including hospital and community quality management staff, and consumers and family members. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Increase/ Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

Goal: Adults served by the Office of Mental Health and who have a serious mental illness will be able to be employed and maintain their employment.

Target: A greater number of individuals with serious mental illness who are receiving mental health services from the Office of Mental Health will be able to secure a job and if working, be able to retain their employment.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are capable of working and who have a job. NOMS Indicator # 5; Table 4 of URS

Measure: Numerator: Number of Persons Employed: Competitively Employed Full or Part-time (Includes Supported Employment).

Denominator: [Employed: Competitively Employed Full or Part-time (includes Supported Employment) + Unemployed + Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)] Note: This excludes persons whose employment status was "Not Available".

Sources of Information: Undetermined, in development

Special Issues: This will be a new indicator for the state. OMH is in the process of exploring the best method to collect information easily and accurately for this indicator and others. One method being explored is the development of a standardized set of Utilization Management forms that would be comprehensive in scope, and would include many of the data items from the previously used POMS (Psychosocial Outcome Measurement Scales). The new process would be packaged in a format that is easily used on a broad cross-section of the population, more automated, and would largely use consumer-generated data. As this is a new measure for the state, initial data collected will be used as a baseline.

Significance: Measuring the number of adults with serious mental illness who are able to work and remain in the workforce, as a result of receiving mental health services, is a significant component of the Recovery movement.

Action Plan: Once the information is available (see above), the Block Grant indicators will be monitored through the Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

Goal: Adults served by the Office of Mental Health and who have serious mental illness will not require the intervention of law enforcement.

Target: A decreasing number of individuals with serious mental illness who are receiving mental health services from the Office of Mental Health will be arrested over time.

Population: Adults diagnosed with Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are arrested in the year subsequent to receiving services compared to the percentage arrested in the year prior to receiving services. NOMS Indicator # 6; URS Table 19A.

Measure: Numerator: Number of people who were arrested in T1 who were not rearrested in T2 (new and continuing clients combined.

Denominator: Number of people arrested in T1 (new and continuing clients combined).

Sources of Information: MHSIP Consumer Survey

Special Issues: This will be a new indicator for the state. Since this question is phrased differently than the current Louisiana format for quantitative survey questions, it is scored differently, and is more sensitive for consumers to respond to, OMH plans to use a version of the TeleSage system to address this Indicator. The on-line tool allows multiple methods of data entry including consumer peer assisted survey completion, direct data entry by clerical staff from an answer sheet completed by the consumer, or computer capture of data from a Teleform. The collected data will be extrapolated to reflect totals for the entire population of those adults with serious mental illness receiving services in CMHCs. This measure will be piloted in FY09.

Significance: Measuring the number of adults with serious mental illness who have decreasing exposure to arrest/ incarceration is a significant factor contributing to improved community function.

Action Plan: See special issues. The Block Grant indicators will be monitored through the Division of Planning, Evaluation, and Information Technology, and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

Goal: Adults served by the Office of Mental Health will live in safe, secure, stable housing.

Target: A decreasing number of individuals with serious mental illness who are receiving mental health services from the Office of Mental Health will need to use shelters for temporary residence of be homeless.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health who are homeless or who have been living in shelters. NOMS Indicator # 7; URS Table 15.

Measure: Numerator: Number of Persons Homeless.
Denominator: From URS Table, all persons with living situation, excluding (minus) persons with Living Situation Not Available.

Sources of Information: ARAMIS

Special Issues: This is a new indicator, and although data for this indicator can be obtained for prior years, Jefferson Parish Human Services Authority (JPHSA) has not been included (not available). As this is a new Indicator for the state, data collected will be used as a baseline for setting targets in FY 2010. Comparisons to previous years will need to be done cautiously given that data from JPHSA was not included in prior years.

Significance: Measuring the number of adults with serious mental illness who are homeless or in shelters will assist in developing resources to provide adequate housing opportunities for individuals, a significant component of the Recovery movement.

Action Plan: The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation, and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities
Name of Performance Indicator: Increased Social Supports/ Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

Goal: Adults with severe mental illness served by the Office of Mental Health will have adequate social support.

Target: Adults with serious mental illness who report that they agree or strongly agree that they are happy with their interpersonal relationships and feelings of being connected with their community will increase.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health that report agreeing or strongly agreeing with statements on the MHSIP consumer survey related to social connectedness. NOMS Indicator #8 in Development.

Measure: Estimated number of adults who have serious mental illness, who are receiving services during the fiscal year (7/1 – 6/30) who report that they agree or strongly agree (score 1 or 2) with statements on the MHSIP survey addressing social connectedness (#33 to 36) divided by the total number of consumers sampled, expressed as a percentage.

Sources of Information: MHSIP standard consumer survey/ C'est Bon Survey

Special Issues: This will be a new indicator for the state. The C'est Bon survey was modified to include the full set of questions from the standard MHSIP survey for adults and was implemented in the summer of 2007. A further enhancement to the state's consumer survey process includes additional items (including social connectedness) on the C'est Bon Survey starting in July of 2008. As this is a new measure for the state, data collected will be used as a baseline for setting targets in FY 10.

Significance: Measuring the number of adults with serious mental illness who experience good social connectedness will be an important indicator of the prognosis for recovery.

Action Plan: The NOMS questions, including social connectedness were included beginning in July, 2008, and will be reported and treated as a baseline for FY 2008-09. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A

Table Descriptors:

Goal: Adults with severe mental illness served by the Office of Mental Health will report having an improved ability to take care of themselves and independently manage their affairs.

Target: Adults with serious mental illness who report that they agree or strongly agree that they are better able to manage themselves and situations to meet their needs will increase.

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults who have a serious mental illness who receive mental health services from the Office of Mental Health that report agreeing or strongly agreeing with statements on the MHSIP consumer survey related to improved functioning. NOMS Indicator #9, in Development.

Measure: Estimated number of adults who have serious mental illness, who are receiving services during the fiscal year (7/1 – 6/30) who report that they agree or strongly agree (score 1 or 2) with statements on the MHSIP survey addressing functionality (#29 to 32) divided by the total number of consumers sampled, expressed as a percentage.

Sources of Information: MHSIP standard consumer survey. / C'est Bon Survey

Special Issues: This will be a new indicator for the state. The C'est Bon survey was modified to include the full set of questions from the standard MHSIP survey for adults and was implemented in the summer of 2007. A further enhancement to the state's consumer survey process includes additional items (including level of functioning) on the C'est Bon Survey starting in July of 2008. As this is a new measure for the state, data collected will be used as a baseline for setting targets in FY 10.

Significance: Measuring the number of adults with serious mental illness who experience improved functional ability will be an important indicator of the prognosis for recovery. It is also a NOMS measure.

Action Plan: The NOMS questions, including social connectedness were included beginning in July, 2008, and will be reported and treated as a baseline for FY 2008-09. The Block Grant indicators will be monitored through the Division of Planning, Evaluation, and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

Name of Performance Indicator: Consumer Housing/ Homeless Access (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	93%	91%	92%	92%
Numerator	549	422	996	
Denominator	589	465	1080	

Table Descriptors:

Goal: People with serious mental illness have assistance with their housing needs as part of access to appropriate, adequate mental health services

Target: Consumers who report they were satisfied with the assistance given to them by OMH in improving their housing situation will increase.

Population: Adults diagnosed with Serious Mental Illness

Criterion: 4: Targeted Services to Rural, Homeless, and Older Adult Populations

Indicator: The percentage of OMH consumers who rate the assistance they received in improving their housing with a 'C' or better.

Measure: Numerator: the number of OMH and MHR consumers surveyed who give C'est Bon Survey Questionnaire a grade of 'C' or better during the fiscal year (7/1- 6/30). Denominator: Total number of OMH and MHR consumers surveyed. (Item #24 - *How would you grade how well the services have helped you improve your housing situation?*)

Sources of Information: C'est Bon Survey

Special Issues: Due to the destruction of many homes as a result of Hurricanes Katrina and Rita, the housing situation in the state continues to be difficult to assess. Recognizing the problems with the destruction of available housing, the Planning Council reduced the target when the modifications were done post- hurricanes. The numerator and denominator are noted to be different when comparing the actual statistics, due in part to difficulties hiring/ keeping consumer interviewers, costs of travel, difficulties in finding motel accommodations, etc. in the state. This has resulted in a smaller sample sizes immediately post-hurricanes, although the performance indicator is remarkably consistent, given the problems with housing since the hurricanes. FY 2008 Actual: 996/1080 X 100= 92%

Significance: Safe, stable housing is a key factor in successful community living.

Action Plan: The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation, and Information Technology, and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities
Name of Performance Indicator: Continuity of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	8.0	8.2	8.3	8.3
Numerator	718	750	631	
Denominator	90	91	76	

Table Descriptors:

Goal: Adults served by the Office of Mental Health will be provided with appropriate recovery/ resiliency-oriented mental health services.

Target: The average number of days between a consumer's discharge from a psychiatric hospital and a follow-up visit to a community mental health clinic (CMHC) will be at the lowest level possible in order to maintain continuity of care

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 2: Mental Health System Data Epidemiology

Indicator: Average number of days between a state psychiatric hospital discharge and a CMHC aftercare appointment

Measure: Days reported (excluding data from Acute Units- both free-standing & within hospital)
Average = Number of days until follow-up divided by number of discharges
Numerator = sum of days from discharge to CMHC admit
Denominator = Discharges with aftercare visit within 45 days
Time period (Lag fiscal year) - April 1 - March 31

Sources of Information: ARAMIS, PIP

Special Issues: This data now *excludes data from all acute units*. The numbers reported here for 2006, 2007, and 2008 have been adjusted to provide for accurate comparisons. In previous years reporting the data included acute units within hospitals, because these numbers had not been separated out. At discharge, patients are routinely given 3 weeks supply of medications, so 21 days is the absolute limit for clients to be seen in the outpatient setting. FY 2008 Actual = 631 / 76 = 8.3 (average)

Significance: One of the strongest predictors of community success after discharge from a state hospital is continuity of care

Action Plan: The Block Grant indicators will be monitored through the OMH Quality Council and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Quality Council sponsors a quarterly Quality Forum that is designed to review OMH performance indicators and provide a venue for dialogues on system quality improvement strategies and action plans. The Forum is attended by a wide range of mental health stakeholders, including hospital and community quality management staff, and consumers and family members. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Expenditure of Block Grant Funds (Consensus = 100)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	100	100	100	100
Numerator	--	--	--	--
Denominator	--	--	--	--

Table Descriptors:

Goal: Mental Health Block Grant funds will maximize the implementation of the Adult Mental Health Block Grant Plan

Target: One-hundred percent (100%) of the Block Grant funds available to Louisiana will be allocated for accomplishing the Mental Health Block Grant Plan's goals and objectives

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 5:Management Systems

Indicator: Allocated funding for adults from the Mental Health Block Grant is in accord with the Mental Health Block Grant Plan

Measure: Consensus of Louisiana Mental Health Planning Council members that the planned expenditure of Block Grant funds as expressed in the State's Block Grant application and the resulting Implementation Report are in accord with the Block Grant Plan. 100% = Consensus

Sources of Information: Louisiana Mental Health Planning Council letter included with the Block Grant Plan application

Special Issues: FY2008 Actual = Consensus = 100%

Significance: The concurrence of the Planning Council and other stakeholders concerning the allocation of Block Grant dollars is important to show the appropriateness of the expenditure of Block Grant funding. Having major stakeholders deem the OMH Intended Use Plan as appropriate is reflective of stakeholder input and an indication that priority areas have been funded.

Action Plan: Appropriate expenditures and accurate accounting will continue to be provided, ensuring the proper usage of Block Grant funds according to the allocations specified in the Intended Use Plans. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation, and Information Technology, and the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Planning Council Satisfaction (percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	87%	91%	100%	91%
Numerator				--
Denominator				--

Table Descriptors:

Goal: Consumers, family members, and other stakeholders are involved in the policy decisions, planning, and monitoring of the mental health system

Target: Individuals who represent adults on State Planning Councils should regard and report their participation as a positive experience

Population: Adults Diagnosed with a Serious Mental Illness

Criterion: 5: Management Systems

Indicator: The percentage of Louisiana Mental Health Planning Council members giving positive feedback regarding their involvement in the Council

Measure: The percentage of Louisiana Mental Health Planning Council members who rate their involvement in the Council with a grade of 'C' or better

Sources of Information: Planning Council meeting evaluation surveys, Planning Council Executive Committee Reports

Special Issues: The numerators and denominators are not available from the Council.
FY 2008 Actual = 100%.

Significance: If council members report that they are involved, it is likely that OMH is providing an environment conducive to stakeholder partnership

Action Plan: The Planning Council will continue to survey its members at each meeting and request suggestions for improvement. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation, and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.

ADULT – GOALS TARGETS AND ACTION PLANS Transformation Activities

Name of Performance Indicator: Regional Advisory Councils

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected/ Actual	FY 2009 Target
Performance Indicator	90	100	90	100
Numerator	9	10	9	--
Denominator	10	10	10	--

Table Descriptors:

Goal: Consumers, family members, and other stakeholders are involved in the policy decisions, planning, and monitoring of the mental health system

Target: All local and Regional Advisory Councils will be fully constituted, trained, active, and formally linked to the Louisiana Mental Health Planning Council

Population: Adults diagnosed with a Serious Mental Illness

Criterion: 5: Management Systems

Indicator: The percent of fully constituted and trained Regional Advisory Councils (RAC's) formally linked to the Louisiana Mental Health Planning Council.
Numerator: number of fully constituted and trained RACs formally linked to the Planning Council
Denominator: number of Regions / LGEs (10)

Measure: Count of fully constituted, trained, active Regional Advisory Councils on June 30 of the fiscal year as verified by Planning Council Regional Advisory Council training staff

Sources of Information: Regional Advisory Councils, Planning Council Executive Committee Reports, Survey of Regions & Districts, and Survey of Hospitals

Special Issues: Problems were encountered with the functioning of RACs prior to the hurricanes in 2005. The hurricanes further disrupted the situation. A further complication occurred in July of 2008 when the liaison left her position. A new liaison was hired, and this individual is committed to working diligently with the regions/ LGEs to have fully functioning and engaged RACs. The differentiation of a RAC as *vs*. a Board has been required in the LGEs.

Significance: Local planning and advocacy is the cornerstone of statewide system change and progress

Action Plan: The Planning Council Liaison will continue to provide training and support to RACs, reporting to OMH and the Planning Council when there are problems. LGEs have been made aware that a RAC is necessary in order to be recipients of Block Grant funding. The Block Grant indicators will be monitored through the OMH Division of Planning, Evaluation and Information Technology and through the Committee on Programs and Services of the Louisiana Mental Health Planning Council. The Planning Council Committee on Programs and Services is responsible for monitoring and evaluation of the mental health system and for recommending service system improvements to the Council.